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EDITOR'S NOTE

Michael Le Huynh[*]

A continuous stream of high quality submissions, two years after an initial open call, is reassuring for the editor of a young journal. A particularly envious position is one where, faced with a growing interest, the editor must choose to expand the number of issues. Thanks to the financial support of the McGill Faculty of Law and its students, the *MJLH* is now able to move to two issues per volume and still provide its content online, free of charge. As such, the *MJLH* remains true to its mandate of publishing current and valuable health law research while at the same time ensuring open access to this legal scholarship.

Our first issue leads off with a short piece by Lawrence Gostin. He proposes two innovative governance structures to address global health disparities. These improve on current international law approaches by, amongst other things, prioritizing populations' basic survival needs and harmonizing the activities of major global health actors.

Dianne Pothier provides a comprehensive review of the Canadian jurisprudence on disability discrimination in the workplace. She argues that judges should replace the ad hoc system of condemning disability discrimination with a systemic approach based on a social model of disability. This model challenges able-bodied norms by preemptively adjusting the environment such that it meets the needs and abilities of all people.

Like the two previous articles, the third proposes an alternative legal framework to address deficiencies—here, in the area of tort law. Rebecca Rodal and Dr. Kumanan Wilson present epidemiological data demonstrating how the decision not to vaccinate one's child can amplify the occurrence of otherwise preventable outbreaks. For parents whose immunized children have contracted a disease, recourse against those parents who have refused to immunize their children is tenuous. The authors discuss current barriers to recovery and the reforms needed to support the tort of 'failure to immunize'.

La *RDSM* a également reçu et sélectionné deux commentaires d'arrêt complémentaires. Chacun se penche sur la décision *A.C. c. Manitoba*, issue de la Cour suprême en 2009. D'une part, Shawn Harmon examine attentivement la façon dont la Cour définit l'autonomie individuelle et ses droits afférents. D'autre part, Robert Kouri explique la pertinence de l'analyse de la Cour dans le contexte du droit québécois.

Je tiens à remercier toute l'équipe de la *RDSM*. Chaque succès de la *Revue* naît des efforts soutenus et de la diligence de nos membres. J'apprécie aussi l'aide apportée par notre comité consultatif. En ce sens, j'aimerais souhaiter la bienvenue aux nouveaux membres du comité : le docteur Philippe Couillard et maître Christine Baudouin. Encore cette année, il importe de souligner le soutien indéfectible de notre superviseure, madame Angela Campbell, qui joue un rôle intégral dans notre organisation. Encore plus que son expérience et ses conseils, c'est son exceptionnel dévouement qui a permis à la *RDSM* de tant progresser en si peu de temps.

À votre santé!

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[*] Editor-in-Chief, McGill Journal of Law and Health, Vol. 4.

TRANSFORMING GLOBAL HEALTH THROUGH BROADLY IMAGINED GLOBAL HEALTH GOVERNANCE

Lawrence O. Gostin[*]

In this article I examine the compelling need for a new global health governance system and propose two innovative solutions.

The global community has widely accepted the normative value of health. Despite this recognition, unsettling disparities persist between the world's rich and poor. Donors' geostrategic goals and philanthropists' idiosyncratic interests perpetuate these disparities because they do not align with populations' dominant health needs. A new approach, therefore, is necessary.

I propose two alternative structures: a Framework Convention on Global Health ("FCGH") or a Global Plan for Justice ("GPJ").

The FCGH requires states to agree to a framework instrument that would establish the broad principles of global health governance. Subsequently, states would adopt specific protocols to create more detailed norms, structures, and processes to achieve the framework objectives. The FCGH contains five primary objectives: (1) prioritizing basic survival needs, (2) building country capacity for enduring, effective health systems, (3) engaging all relevant stakeholders to leverage their resources and expertise, (4) coordinating and harmonizing activities among global health actors, and (5) establishing minimal funding levels for international development assistance for health and requiring accountability for those commitments.

The GPJ would be a voluntary compact among states and private partners. It would entail creation of a Global Health Fund through which funding targets would be established. The GPJ's priorities include: fairly allocating essential medicines and vaccines, meeting basic survival needs, and mitigating health impacts of climate change. This soft-law approach could help animate state acceptance of norms.

Finally, I discuss the Joint Learning Initiative on National and Global Responsibility for Health launched by Georgetown Law's O'Neill Institute for National and Global Health Law, in partnership with academic and civil society groups throughout the world. This initiative would propel a bottom-up social movement to support the creation of a new global health governance structure. It would do so by involving key stakeholders in expounding the goods and services comprised by the right to health, the obligations of states, and a global architecture to improve health.

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INTRODUCTION

Health plays a fundamental role in our lives as individuals and as members of society. At the individual level, health is critical to a person's wellbeing and can affect his or her opportunities in the world. Health is also important to public welfare because a basic level of human functioning is a necessary condition for the development and stability of economic, social, and political structures within a society.

International norms recognize the special value of human health. A primary function of the United Nations is the protection of global health.[1] The Constitution of the World Health Organization ("WHO") expresses the universal aspiration that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," essential to the attainment of peace and security.[2] The human right to health became a treaty obligation for most states under the *International Covenant on Economic, Social and Cultural Rights*[3]—an obligation reiterated in multiple human rights treaties.[4]

Moreover, the United Nations Committee on Economic, Social and Cultural Rights ("CESCR") has offered guidance concerning the norms, obligations, violations, and implementation of the right to health,[5] and has appointed a Special Rapporteur to continue to improve its meaning and effectiveness.[6] These human rights obligations may lack specificity, as well as effective mechanisms of monitoring, accountability, and enforcement. Nevertheless, they reflect a broad international consensus about the normative value of health.

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[1] Article 55 of the *Charter of the United Nations* states that a primary objective of the UN is to promote "higher standards of living" and "solutions of international … health" (26 June 1945, Can. T.S. 1945 No. 7 (entered into force 24 October 1945)).

[2] *Constitution of the World Health Organization*, (Official Records of the World Health Organization, 2, 100), (adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force 7 April 1948), preamble, online: WHO <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

[3] 993 U.N.T.S. 3 (adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with art. 27).

[4] See e.g. *International Convention on the Elimination of All Forms of Discrimination Against Women*, 1249 U.N.T.S. 13 (opened for signature on 1 March 1980, entry into force 3 September 1981, in accordance with art. 27(1) [protecting women's right to health]) art. 12; *International Convention on the Elimination of All Forms of Racial Discrimination*, 660 U.N.T.S. 195 (adopted and opened for signature and ratification by General Assembly resolution 2106 (XX) of 21 December 1965, entry into force 4 January 1969, in accordance with art. 19 [protecting the right to public health for racial minorities]) art. 5(e)(iv); *Convention on the Rights of Persons with Disabilities*, UN doc. A/61/611 (opened for signature 30 March 2007, entry into force 3 May 2008, in accordance with art. 45(1)) art. 25.

[5] UN Committee on Economic, Social and Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, UN ESCOR, 22d Sess., General Comment No. 14: The Right to the Highest Attainable Standard of Health, Agenda Item 3, UN Doc. E/C.12/2000/4 (2000), online: UNHCR—The UN Refugee Agency <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En> [UN CESCR, *Implementation of the International Covenant*].

[6] UN Commission on Human Rights, *Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt*, UN ESCOR, 61st Sess., U.N. Doc. E/CN.4/2005/51 (2005) [UN CHR, *Economic, Social and Cultural Rights Report, 2005*]. See also UN Commission on Human Rights, *Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt*, UN ESCOR, 59th Sess., UN Doc. E/CN.4/2003/58 (2003); Paul Hunt, "The UN Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions" (2003) 7:1 Health & Hum. Rts. 1; UN Human Rights Council, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*, UN GAOR, 11th Sess., UN Doc. A/HRC/11/12 (2009).

The Millennium Development Goals ("MDGs")—a global compact to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water, and environmental degradation by 2015—similarly illustrate a global consensus around the health and development agenda. Three of the eight goals (four, five, and six) relate to health: reduce child mortality; improve maternal health; and combat AIDS, malaria, and other diseases.[7]

Despite robust ethical justifications and international norms concerning enhanced global health, unconscionable disparities in health exist between the world's rich and poor. At present, the world's poor bear a vastly disproportionate burden of disease and injury. As life expectancy has steadily increased in the developed world, the rate of increase has slowed in lower-middle income countries, and some sub-Saharan and transitional states have seen decreases.[8] Health disparities between the rich and poor, however, cannot be simplified to a division between rich and poor countries. Rather, health disparities also exist within countries because different levels of health are linked to socio-economic conditions.[9] These conditions frequently correlate with other determinants of health, such as smoking.[10] As a result, the health risks that some disadvantaged groups in high-income countries experience are more similar to those in developing regions, such as sub-Saharan Africa, than to those of their better positioned compatriots.[11] In addition, many of the health problems of poor countries can threaten wealthier countries as diseases have the ability to migrate rapidly across the globe. Hence, the concept of global social justice (or global health equity) promotes the attainment of health for the world's population.

The glaring health disparities between the world's rich and poor can be attributed to social and economic factors.[12] Addressing these factors, which are commonly referred to as the social determinants of health, can dramatically improve the patterns of systematic disadvantage that profoundly and persuasively undermine prospects for wellbeing of the poor. For example, a lower socioeconomic status (as determined by education, occupation, and income) is strongly correlated to poor health outcomes due to conditions of material disadvantage, diminished control of life circumstances, and lack of social acceptance.[13] In addition, factors such as daily living conditions, the built and natural environment, and equitable distribution of power and resources can have an impact on health.

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[7] UN Department of Economic & Social Affairs, *Millennium Development Goals Report (2006)*, online: UN <http://www.un.org/millenniumgoals>.

[8] People's Health Movement, Medact & Global Equity Gauge Alliance, *Global Health Watch 2: An Alternative World Health Report* (London: Zed Books, 2008) at 11 [*Global Health Watch 2*].

[9] Lawrence Gostin, "The Unconscionable Health Gap: A Global Plan for Justice" (2010) 375 The Lancet 1504 [Gostin, "Unconscionable"]; Lawrence O. Gostin, "Redressing the Unconscionable Health Gap: A Global Plan for Justice" (2010) 4:2 Harvard Law and Policy Review 271 [Gostin, "Redressing"].

[10] See Christopher J.L. Murray *et al.*, "Eight Americas: Investigating Mortality Disparities Across Races, Counties, and Race-Counties in the United States" (2006) 3:9 PLoS Medicine 1513 at 1522.

[11] *Ibid.* at 1516, 1520, 1522 (noting that Blacks in the age group 15-44 living in high-risk urban areas have mortality risks more similar to ones in the Russian Federation and sub-Saharan Africa).

[12] WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (Final Report of the Commission on Social Determinants of Health)* (Geneva: WHO Press, 2008), online: WHO <http://www.who.int/social_determinants/thecommission/finalreport/en/>.

[13] See generally B. Aldabe *et al.*, "Contribution of Material, Occupational, and Psychosocial Factors in the Explanation of Social Inequalities in Health in 28 Countries in Europe" (2010) Journal of Epidemiology & Community Health 1; Carme Borrell *et al.*, "Social Class and Self-Reported Health Status Among Men and Women: What is the Role of Work Organisation, Household Material Standards and Household Labour?" (2004) 58:10 Social Science & Medicine 1869; M.G. Marmot *et al.*, "Employment Grade and Coronary Heart Disease in British Civil Servants" (1978) 32:4 Journal of Epidemiology and Community Health 244.

The international community is well aware of the glaring problem of health inequalities,[14] but deeply resistant to taking bold remedial action. International development assistance for health ("IDAH") appears much more concerned with the geostrategic and philanthropic interests of donors than the health needs of the poor.[15] Foreign aid, as currently structured, lacks scale and sustainability, while failing to address the key determinants of health. As a result, the world remains fundamentally unfair in its distribution of human health "goods". This causes enormous physical and mental suffering by those who experience the compounding disadvantages of poverty and ill health.

I

BUILDING NEW SOLUTIONS IN GLOBAL HEALTH

In light of the challenges outlined above, global health governance requires a bold and innovative approach.[16] While a number of new initiatives have emerged to address problems of cooperation and coordination relating to global health, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the International Health Partnership, these approaches do not go far enough. A much more comprehensive global health response that tackles the fundamental issues is needed to address current and future problems, especially those faced by the world's poor and vulnerable.

International law can serve as a means to address grave problems of transnational significance that no single country or group of states can solve on their own. Global health, as a result, deserves to be a major focus in international law, but this has not been the case. In order to fill this void and to use international law in a more constructive manner, a new model of global healthcare governance will be necessary to channel more cooperative action and to get to the heart of the global health dilemma—building long-term capacity for poor countries to take ongoing responsibility for their own health in collaboration with other actors (i.e., transitional and rich countries, intergovernmental organizations, businesses, foundations, and civil society). I have proposed two, interrelated, structural legal mechanisms to dramatically improve global health governance: (A) a Framework Convention on Global Health[17] and (B) a Global Plan for Justice.[18]

A. Framework Convention on Global Health

The Framework Convention on Global Health ("FCGH") recognizes the power of international law in global health. Transnational problems of global health demand a stable commitment of resources for the long-term and a prioritization of these resources toward genuinely effective interventions. Such attributes require a governance mechanism that helps establish priorities, coordinate efforts, foster public-private partnerships, and allow poor countries to take ownership of policies and programs in a competent and transparent manner. To address this need, the FCGH promotes a treaty-based, "bottom up" approach to global health governance that is structured around the following key objectives.

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[14] See e.g. *Reducing Health Inequities through Action on the Social Determinants of Health*, WHA Res. 62.14, WHA (22 May 2009), online: WHO <http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf>; Lee Jong-wook (former Director-General of the World Health Organization), Address to the 57th World Health Assembly, WHA (17 May 2004), online: WHO <http://www.who.int/dg/lee/speeches/2004/wha57/en/>.

[15] See *infra* notes 42-45 and accompanying text.

[16] Lawrence O. Gostin & Emily A. Mok, "Grand Challenges in Global Health Governance" (2009) 90 British Medical Bulletin 7.

[17] *Ibid.*

[18] See Gostin, "Redressing", *supra* note 9.

1. *FCGH Objectives*

The first objective of the FCGH is to set priorities so that international assistance is appropriately directed at meeting basic survival needs. A persistent problem in global health has been the lack of donor resource alignment with activities that reflect the true burden of disease or address the underlying determinants of health in poor countries. Hence, there is an urgent need for a governance mechanism that facilitates evidence-based consensus building and communal priority-setting.[19]

Another objective of the FCGH works to build country capacity for enduring and effective health systems. Capacity building for health systems involves developing a country's human resources, organizational structures, and infrastructures so that all elements of the health sector can perform their core functions and meet the population's basic needs in a sustainable manner.[20] For example, by building a strong infrastructure, a country will be better equipped to detect, prevent, respond to, and treat disease, particularly among the most vulnerable. Capacity building, however, requires a fundamental shift in how international assistance for health has been provided to date. It requires the long-term commitment of all parties—both developed and developing countries and their partners—for the health of their populations. It also involves a change from the prevailing top-down approach that privileges the ideas and priorities of intergovernmental organizations and foreign governments over local leaders as well as a move beyond simply tabulating how much money has been donated.[21]

A third objective of the FCGH is to engage all stakeholders, both state and non-state actors, so that they can bring to bear their resources and expertise. It is essential to harness the ingenuity and resources of non-state actors (including NGOs, private industry, foundations, public-private hybrids, and civil society) because no single entity has the capability to solve today's daunting global health crises. The FCGH would include these major stakeholders in the process of negotiation, debate, and information exchange as well as reduce barriers for them to actively engage in capacity building.

The fourth objective of the FCGH is to coordinate and harmonize the activities among the current proliferation of global health actors. By having the FCGH set priorities and engage all major stakeholders, it is also imperative for this governance scheme to promote a new means for coordination. This will require more than a simple accounting of how much money has been spent by the donor community. In the currently fractured environment where states, NGOs, IGOs, and foundations all fund and prioritize different health interventions, establishing coordination will be essential.

The FCGH's final objectives are to establish minimal funding levels for international development assistance for health and to hold the actors accountable for their commitments through rigorous monitoring and evaluation. By establishing the FCGH as an ongoing diplomatic forum with established principles and defined obligations, the FCGH can help to transcend the current ebbs and flows of interest in international assistance for global health as well as shifts in political will. In addition, the FCGH would build in compliance measures as a component of this global health governance regime.

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[19] Sally K. Stansfield, "Philanthropy and Alliances for Global Health" in Inge Kaul, Katell Le Goulven & Mirjam Schnupf, eds., *Global Public Goods Financing: New Tools for New Challenges* (New York: UNDP/ODS, 2002) 94.

[20] Anneli Milèn, *What Do We Know About Capacity Building? An Overview of Existing Knowledge and Good Practice* (Geneva: World Health Organization, 2001).

[21] Merilee S. Grindle, ed., *Getting Good Government: Capacity Building in the Public Sectors of Developing Countries* (Cambridge, MA: Harvard Institute for International Development, 1997). See also Milèn, *ibid.*

2. *Advantages and Barriers to the FCGH*

Procedurally, the formation of the FCGH involves a framework convention-protocol approach that, in essence, is a process of incremental regime development. In the initial stage, states would negotiate and agree to the framework instrument, which establishes the broad principles for global health governance: goals, obligations, institutional structures, empirical monitoring, funding mechanisms, and enforcement. In subsequent stages, specific protocols would be developed to achieve the objectives in the original framework. These protocols, organized by key components of the global health strategy,[22] would create more detailed legal norms, structures, and processes. The framework convention-protocol approach provides states with considerable freedom to decide the level of specificity that is politically feasible in the present, saving the more complex or contentious issues to be built into later protocols. This avoids the problem of political bottlenecks over contentious elements that could hold talks at a standstill and prevent progress. The FCGH process also confers the advantages of: facilitating global consensus through a stepwise, incremental manner; fostering a shared humanitarian instinct through normative discussion, which can help to educate and persuade the various parties; and, building factual and scientific consensus through the collection and analysis of health data and scientific evidence.

Yet, the FCGH is not a panacea and there exist various social, political, and economic barriers to its creation. The framework convention-protocol approach cannot easily circumvent some current aspects of global health governance: the domination of the most economically and politically powerful countries; the deep resistance to creating obligations to expend, or transfer, wealth; the lack of confidence in international legal regimes and trust in international organizations; and, the vocal concerns about the integrity and competency of governments in many of the poorest countries. Furthermore, it does not ensure consensus on contentious issues. The framework convention's lengthy, incremental process could encounter a loss in momentum or the derailment of subsequent protocols due to its extended timeframe. Nevertheless, given the dismal nature of extant global health governance, a FCGH may be a risk worth taking.

B. A Global Plan for Justice

To overcome the challenges of the FCGH approach, I have also proposed an alternative model for the governance of global health—the Global Plan for Justice ("GPJ").[23] This approach involves the creation of a voluntary compact among countries and their private partners (e.g., businesses, philanthropic organizations, and civil society) to redress current global health inequities. The GPJ focuses on three core global health priorities, which address the most critical determinants of health for the world's poor. These core priorities are (1) fairly allocating essential medicines and vaccines, (2) meeting basic survival needs, and (3) mitigating the health impacts of climate change.

1. *Fair Allocation of Essential Medicines and Vaccines*

It is important to ensure the fair allocation of essential medicines and vaccines, especially in relation to the needs of low- and middle-income countries. Essential medicines and vaccines, according to the WHO, "are those [treatments] that satisfy the priority health care needs of the population."[24] Such treatments are necessary in the prevention and mitigation of human suffer-

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[22] The Framework Convention on Tobacco Control ("FCTC"), for example, anticipates that issues such as advertisement, illicit trade, and treatment will be addressed individually in separate protocols: World Health Organization, *Framework Convention on Tobacco Control*, 2003, WHO Doc. A56/VR/4, online: WHO <http://www.who.int/entity/tobacco/framework/WHO_FCTC_english.pdf>.

[23] See Gostin, "Redressing", *supra* note 9.

[24] World Health Organization, "Essential Medicines", online: WHO <http://www.who.int/medicines/

ing and play a critical role in addressing both chronic needs and emergency situations. Yet access to essential medicines has proven difficult in many developing countries, due to restrictively high prices for patented medicines and the lack of research investment for treatments targeted at diseases of poverty.[25]

Public health emergencies, such as the recent H1N1 pandemic, underscore the immediate and crucial need for the fair allocation of vaccines and medicines. When a mass disaster strikes, it almost inevitably leads to scarcity in medical resources caused by a limited supply and a surge in demand. Poor states, which are at greatest risk of serious illness and death from the spread of new infections, tend to be left behind as rich states hoard the available lifesaving medicines and vaccines for themselves—further widening the already large health disparities between the rich and poor. Such a trajectory is troubling for the state of global health as the allocation of resources to the world's most vulnerable is likely to confer the most beneficial effect on levels of morbidity and premature mortality.[26]

2. *Meeting Basic Survival Needs*

Another key priority of the GPJ is meeting basic survival needs through the provision of fundamental services and functions such as sanitation and engineering, health systems infrastructure and capacity building, and primary health care. Sanitation and engineering play a pivotal role in establishing sustainable development and health. Through cost-effective interventions that address waterborne, mosquito-borne, and rodent-borne diseases, such basic services hold massive potential to improve the health of the world's poorest populations. Building up health systems infrastructure and capacity is another component to ensuring population health. Governments function to identify, prevent, and ameliorate risks to public health. By helping developing country governments attain sound infrastructures (e.g., disease surveillance laboratories and data systems) and a competent workforce, they will have the tools needed to protect their people and the ability to discover solutions to their problems. Primary health care, which is defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible [and affordable],"[27] is also a critical function upon which human survival is dependent. Components of primary health care include counseling, maternal and child health, family planning, and medical treatment.

The GPJ does not necessitate advanced tertiary care centers or even highly specialized physicians; rather, it simply requires essential health personnel (e.g., family doctors, nurses, midwives, and community health workers) to diagnose and treat the most common injuries and diseases, care for pregnant women and safely deliver babies, and teach people how to live safely. It also promotes individual and community self-reliance and participation in the planning, organization, operation, and control of health services, making fullest use of local and national resources. While attaining such everyday survival needs may lack the glamour of high-technology medicine or dramatic rescue, they possess the real potential to bestow a major impact upon population health because they deal with the underlying causes of common disease and disabilities.

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services/essmedicines_def/en/index.html>.

[25] *Global Health Watch 2*, *supra* note 8 at 88-89.

[26] Lawrence O. Gostin, "Pandemic Influenza: Public Health Preparedness for the Next Global Health Emergency" (2004) 32:4 J.L. Med. & Ethics 565.

[27] World Health Organization, *Declaration of Alma-Ata* (Copenhagen: WHO Regional Office for Europe, 1978) art. 6, online: WHO <http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf>.

3. *Mitigating the Health Impacts of Climate Change*

The GPJ's third priority seeks to address the problem of climate change because of the severe impact that it can have on human health in the poorest countries. Climate change brings increasingly intense and frequent natural disasters, which can lead to greater public health emergencies and additional devastation to daily living conditions through water contamination and infrastructure collapse. It can also lead to severe ecosystem changes that will impair crop, livestock, and fishery yields, subsequently increasing hunger and famine. Furthermore, climate change holds the potential to broaden the geographic range of disease vectors as well as exacerbate air pollution through increased temperatures.[28] While the effects of climate change will be felt in every region of the world, it will disproportionately burden the poor and lead to a greater gap in health disparities globally. These populations already experience major daily disadvantages, such as the scarcity of clean water and nutritious food, as well as high levels of infectious and chronic diseases. These challenges are compounded by the fact that they lack the capacity to ameliorate the potentially devastating effects of climate change due to weak national health care systems, poor infrastructures, and reduced technological and manufacturing capabilities to adapt to rapidly changing environmental conditions.

Climate change not only challenges the international community to find solutions to mitigate its health effects, but also challenges them to address the inevitable questions of global social justice. To address such concerns in the developing world, the GPJ calls for the adoption of two strategic actions on climate change. One action is to incorporate land-use and agricultural migration (such as avoiding deforestation and degradation) and to pursue sustainable agricultural practices. The second action involves fully funding adaptation projects as a global priority. Adaptation programs are aimed at altering natural or human systems in order to prepare populations to survive the effects of climate change.[29]

The linkages between climate change and health highlight the necessity of not only mitigating further climate change, but also implementing strategies for adaptation in order to enhance a population's resilience and reduce its vulnerability to observed or expected changes in the climate. Hence, it will be important to develop policy strategies that address the various human effects of climate change (such as disease, air quality, natural disasters, food and water supply) and to consult with public health experts during this process so that funds are properly applied for the adaptation of human systems.

4. *Implementating the GPJ*

Responding to the three global health priorities above, the GPJ could be established through a World Health Assembly resolution and administered by the WHO. The Director-General of the WHO could facilitate states and their non-state partners in the negotiation of funding commitments, spending priorities, an allocation system, and mechanisms for monitoring, compliance, and implementation. A special feature of this approach includes the establishment of a "Global Health Fund",[30] which is modeled off of the current Global Fund addressing AIDS, tuberculosis, and malaria. Through the Global Health Fund, achievable annual funding targets could be established for states based on their ability to pay and these funds could be prioritized and allocated based on the health needs of developing countries through measures of poverty, morbidity, and premature mortality.

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[28] Ulisses Confalonieri *et al.*, "Human Health" in M.L. Parry *et al.*, eds., *Climate Change 2007: Impacts, Adaptation and Vulnerability* (Cambridge, U.K.: Cambridge University Press, 2007) 391 at 408.

[29] Ira R. Feldman & Joshua H. Kahan, "Preparing for the Day After Tomorrow: Frameworks for Climate Change Adaptation" (2007) 8:1 Sustainable Development Law & Policy 61.

[30] Gorik Ooms & Rachel Hammonds, "Correcting Globalisation in Health: Transnational Entitlements Versus the Ethical Imperative of Reducing Aid-Dependency" (2008) 1:2 Public Health Ethics 154.

The GPJ's structural and procedural flexibility as a voluntary compact holds the promise of overcoming the challenges of achieving a formal multilateral treaty, such as the FCGH. While the FCGH offers a broadly imagined global health governance system for coordinating actors, setting funding levels and priorities, and harnessing the creativity of non-state actors, the political obstacles identified earlier limit its prospects for success. This does not mean that global health advocates should not continue to press the case for a global health convention, and press it hard. The continued "bottom up" agitation for a meaningful global health convention could bear fruit in the future. In the interim, however, the GPJ may be more appealing to states because it does not impose mandatory international obligations upon them.

Understandably, some critics assert that a voluntary compact would be less likely to hold powerful states accountable; however, the global health sector (as opposed to international trade) has never developed mechanisms for adjudication and enforcement, and is unlikely to do so in the near future. The trade-off between a binding and voluntary compact may be worth assuming because soft law can gradually alter state behavior and develop the necessary critical mass for state acceptance of agreed upon norms. To ensure progress, it will be necessary first to persuade states to voluntarily assume obligations, with soft, rather than hard, targets and enforcement as the creation of binding international obligations of health justice must be built over time. This process also provides the opportunity to call upon the WHO to exercise its constitutional powers in the establishment of norms and to assume a greater leadership role in global health.

II

ENVISIONING THE FUTURE OF GLOBAL HEALTH GOVERNANCE: A "JOINT LEARNING INITIATIVE" ON NATIONAL AND GLOBAL RESPONSIBILITY FOR HEALTH

Achieving an innovative global health governance system is far from easy—whether it is a formal treaty such as a FCGH or even a voluntary compact in the form of a GPJ, with resources devoted through a Global Fund for Health.[31] Before a bold plan can gain international support—particularly among rich states that often set the global health agenda, but are deeply resistant to international solutions—it will be necessary to build an international consensus through civil society action.[32] The most transformative changes in global health have come from "bottom-up" social movements, such as campaigns to rid the world of landmines[33] and fight the scourge of HIV/AIDS.[34]

To achieve such a consensus, an international group of experts, in cooperation with the Oslo 7 Group of Nations,[35] is proposing to launch a *Joint Learning Initiative on National and Global Responsibility for Health* ("Joint Learning Initiative").[36] The Joint Learning Initiative would undertake a wide participatory process that includes major stakeholders, such as Intergovernmental Organizations ("IGOs"), states, foundations, public/private partnerships, and civil society. This plan of broad engagement should ensure acceptance and legitimacy.

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[31] *Ibid.*

[32] Mark Heywood & John Shija, "A Global Framework Convention on Health: Would it Help Developing Countries to Fulfill their Duties on the Right to Health? A South African Perspective" J.L. Med. & Ethics (forthcoming in 2010).

[33] International Campaign to Ban Landmines, online: ICBL <http://www.icbl.org/index.php>.

[34] *Treatment Action Campaign v. Minister of Health* (2001), [2002] 4 B. Const. L.R. 356 (T) (S. Afr.).

[35] See the Global Health and Foreign Policy initiative launched by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, "Oslo Ministerial Declaration—Global Health: a Pressing Foreign Policy Issue of our Time" (2007) 369 The Lancet 1373.

[36] Lawrence O. Gostin *et al.*, "The Joint Learning Initiative on National and Global Responsibility for Health" (Background Paper for the Oslo 7, May 2010) (unpublished, on file with author).

Civil society, in fact, is already moving rapidly toward a broad health rights and social justice agenda, characterized by the People's Health Movement[37] and the South African AIDS Action movement.[38] Yet, a well defined framework that expounds the individual rights to health and corresponding state and international community obligations announced by this civil society movement does not exist.

The Initiative, therefore, is structured around four critical issues the international community must address: (A) a core package of essential health services and goods, (B) states' duties toward their own inhabitants, (C) rich countries' responsibility toward the world's poor, and (D) a global architecture to improve health and reduce disparities. Defining the contours of this structure is the need to move beyond the concept of "aid" and toward mutual responsibility and international obligations of justice.

A. What Are the Essential Services and Goods Guaranteed to Every Human Being Under the Right to Health?

The principal question for the Joint Learning Initiative is to determine the basic package of health services and goods that every person has a right to expect. Without an answer to this question, it is impossible to determine what states have a duty to provide to their inhabitants as well as the extent to which affluent states should enhance low and middle-income countries' capacities.

The WHO estimates that a basic set of health services costs as little as US$40 per person per year, which varies depending on the socioeconomic conditions and the burden of disease.[39] This may be a basic minimum level, and additional resources could bring the greater health and well-being that all people deserve. Yet, truly effective global health governance, even within present resource constraints, could achieve great strides in improving the lives of the world's least healthy people.

The United Nations is actively clarifying and expanding its understanding of the right to health through successive reports from the Special Rapporteur.[40] The Committee for Economic, Social and Cultural Rights defined states' core obligations for the right to health to be meaningful; all people should have, at least: access to health services, access to the minimum essential food which is nutritionally adequate and safe; and access to basic shelter, housing and sanitation, and an adequate supply of safe drinking water.[41] The core goods and services include all those necessary for people to lead lives in which they can function and gain the capacity for human agency.[42]

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[37] "People's Health Movement", online: <http://www.phmovement.org>.

[38] AIDS Law Project ("ALP") has recently launched Section 27, a new organization that combines the use of law with human rights advocacy to support and advance campaigns for social justice and human rights in South Africa, online: SECTION27 <http://www.section27.org.za>.

[39] World Health Organization Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO, 2001) at 16, 57 [WHO, *Macroeconomics and Health*].

[40] UN CHR, *Economic, Social and Cultural Rights Report,* 2005, *supra* note 6; Office of the United Nations High Commissioner for Human Rights, "Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines", online: OHCHR <http://www2.ohchr.org/english/issues/health/right/docs/Guidelinesforpharmaceuticalcompanies.doc>.

[41] UN CESCR, *Implementation of the International Covenant*, *supra* note 5.

[42] Amartya Sen, *Development as Freedom* (New York: Alfred A. Knopf, 1999).

B. What Do All States Owe their Population in Terms of Health?

Individual states hold the primary responsibility to assure the conditions for the health of their inhabitants. This requires that governments, within their capacity, provide the funding for and the delivery of all the essential goods and services guaranteed to every human being under the right to health. However, the duty of states should not only be to their own people, but also to the international community to contain health threats that endanger other countries and regions. More generally, state obligations should extend to fostering a functioning interdependent global community, in which all feel and know that our mutual survival is considered to be a matter of common concern. The elements of a state's obligations to its inhabitants should include, at least, the following:

(a) *Adequate health resources within a state's capacity*. The international human right to health posits that governments must ensure a minimum package of essential goods and services. Many countries also have constitutional entitlements to health, life, and a safe environment that require the provision of basic health services. Despite these domestic and international norms, developing country health expenditures as a proportion of total government spending are significantly lower than the global average (<10% compared with >15%).[43] Foreign assistance accounts for 15% of total health expenditures in low-income countries, and is as high as two thirds in some low-income countries. Worse still, developing countries often reduce their domestic health spending in response to increasing international assistance—the so-called "substitution effect", or "fungibility".[44] These data suggest that low-income countries should do much more to ensure the right to health for their inhabitants.

(b) *State responsibility to govern well*. The concept of "good governance" sets consistent standards for national management of economic and social resources for development. Those who exercise authority to expend resources and make policy have a duty of stewardship—a personal responsibility to act on behalf, and in the interests, of those whom they serve. Sound governance is *honest*, in the sense that it is avoids corruption, such as public officials seeking personal gain or diverting funds from their intended purposes. It is *transparent*, in the sense that institutional processes and decision-making are open and comprehensible to the people. It is *deliberative* in the sense that government consults with stakeholders and the public in a meaningful way, giving them the right to provide genuine input into policy formation and implementation. Finally, good governance is *accountable*, in the sense that leaders give reasons for decisions, assume responsibility for successes or failures, and the public has the opportunity to disagree and change the direction. Good governance enables states to formulate and implement sound policies, manage resources, and provide services efficiently.

(c) *State responsibility to fairly and efficiently allocate health resources*. States should have the authority and discretion to set their own health priorities. Yet, in doing so, they have a responsibility to ethically allocate life-sustaining, yet often scarce, resources. States, therefore, must fairly and efficiently distribute health goods and services to its entire population. This requires paying special attention to the needs of the most disadvantaged in society such as the poor, minorities, women, children, and persons with disabilities. Furthermore, it requires that health services are accessible and acceptable irrespective of language, culture, religion, or geography.

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[43] World Health Organization, "Health Expenditures: Ratios and Per Capita Levels by World Bank Income Group" (2010), online: WHO <http://www.who.int/nha/country/regional_averages_by_wb_income_group-en_2010.xls>.

[44] Chunling Lu *et al.*, "Public Financing of Health in Developing Countries: A Cross National Systematic Analysis" (2010) 375:9723 The Lancet 1375.

C. What Do All States Owe to the World's Least Healthy People?

To what extent are states responsible for the provision of health-related goods to the inhabitants of other states? The answers to the first and second questions above will largely provide the answer to the third question: once we agree upon the essential package of health-related goods and on the limits of state capacity to provide it, we will have a clear picture of the financial and technical assistance that capable states should provide.

Unfortunately, the vast burden of morbidity and premature mortality rests on those who have the least capacity to do anything about it. Again, the WHO estimates that a basic set of health services costs as little as US$40 per person per year.[45] George Schieber and colleagues suggest that low-income countries can raise, through taxes, no more than 17% of their Gross Domestic Product ("GDP") due to low formal-sector employment, low urbanization, and weak tax administration capabilities.[46] If these states were to allocate 15% of their government revenue to health-related goods (i.e. 2.55% of their GDP), as African heads of state promised in the Abuja Declaration,[47] only states with a per capita GDP of more than US$1,568 would have the domestic capacity to provide the essential package of health-related goods. About 38% of the world's people live in countries where the average yearly per capita GDP is less than US$1,568, which demonstrates that other countries will need to contribute.[48]

While the volume of global financial responsibility for global health certainly matters, it is not the only concern. An equally important concern is the long-term reliability of global financial responsibility. Financial assistance for health is typically provided in the form of grants with limited duration: three to five years. The global community seems to believe that this will encourage poor states to take their fate in their own hands, and mobilize additional domestic resources. Paradoxically the real effect might be quite the opposite. As Mick Foster explains:

> donor commitments to individual countries remain short-term and highly conditional and do not come close to reflecting these global promises of increased aid, while donor disbursement performance remains volatile and unreliable. Governments are therefore understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.[49]

But that does not mean they will refuse the financial assistance that is available. It is more likely that they will fail to increase, or that they even decrease, their domestic contribution to the provision of health-related goods, as that is the only way to absorb the additional financial assistance without increasing the public expenditure.[50]

From this perspective, financial assistance that is not based on an understanding of mutual responsibility (and therefore unreliable in the long run) is an inefficient expenditure of resources, as it does not improve the provision of health-related goods. This reason alone should be sufficient to consider a global agreement on norms that clarify the national and the global responsibility for health, as it would transform ineffective short-term financial assistance into effective sustained financial contribution.

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[45] WHO, *Macroeconomics and Health*, *supra* note 39.

[46] George J. Schieber *et al.*, "Financing Global Health: Mission Unaccomplished" (2007) 26:4 Health Affairs 921.

[47] Organization of African Unity, *Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases*, OAU/SPS/ABUJA/3 (2001), at para. 26, online: UN <http://www.un.org/ga/aids/pdf/abuja_declaration.pdf>.

[48] International Monetary Fund, *World Economic Outlook Database: April 2010 Edition*, online: IMF <http://www.imf.org/external/pubs/ft/weo/2010/01/weodata/index.aspx>.

[49] Mick Foster, "Fiscal Space and Sustainability: Towards a Solution for the Health Sector" (Paper for the 3rd meeting of the High-Level Forum on the Health MDGs, 2005) at ii, online: Mick Foster Economics Limited <http://www.mickfoster.com/docs/FiscalSpaceTowardsSolution.pdf>.

[50] Gorik Ooms *et al.*, "Crowding Out: Are Relations Between International Health Aid and Government Health Funding Too Complex to be Captured in Averages Only?" (2010) 375:9723 The Lancet 1403.

D. What Kind of Global Health Governance Mechanisms Are Required to Make All States Live Up to their Mutual Responsibilities to Provide Health-Related Goods to All?

The preliminary answers to the questions above should be sufficient to understand the need for a better global health governance mechanism—one based on true global partnerships for health. Several noteworthy considerations follow. First, states where the people whose survival is most at risk will only accept international norms for their domestic health challenges if it is part of a genuine partnership for a global common good, which confirms their duties towards the international community but also the duties of the international community towards them. Second, affluent states will be reluctant to accept financial duties towards poor states, unless there is an agreed arrangement for equitable burden-sharing among all affluent states, and unless there are agreed norms about how these financial duties will complement domestic duties, and for which health-related goods they will be used. Third a lack of adequate domestic health spending and any misuse of global financial resources by national governments would seriously undermine the willingness of the international community to live up to their responsibilities. Last, the collection, management, and coordination of the global financial duties for global health will have to be governed by a body that reflects the global partnership—financial assistance as the counterpart for operational efforts to provide a basic package of health-related goods and services to all people, and vice versa—in which all states are equally represented, and in which the civil society of poor and affluent states has a meaningful voice.

The global health governance architecture the Joint Learning Initiative is looking for would have to reinforce the leadership and normative role of the WHO, and simplify the present architecture of global financial assistance for health. It must have the legitimacy and authority to assess poor states' health plans and domestic contributions, as well as to provide support to poor states that have state of the art health plans but have exhausted their domestic resources (i.e., no further conditions should be imposed).

CONCLUSION

As the current state of global health continues to struggle with a complex and jumbled array of actors and initiatives, along with increasingly limited resources, a rational governance solution remains glaringly at large. The Joint Learning Initiative asks the vital questions, and builds a global consensus toward more durable solutions such as a Framework Convention on Global Health or a Global Plan for Justice, with resources devoted through a Global Fund for Health.

What is most important is to use global health advocacy to stimulate current thinking about governance in a new and bold direction. This will require cooperation and deliberative action by a wide range of stakeholders. Stagnancy in global health will only result in further devastation and greater inequities; hence, action in reforming global health governance must be taken now.

TACKLING DISABILITY DISCRIMINATION AT WORK: TOWARD A SYSTEMIC APPROACH

Dianne Pothier[*]

Approaching disability discrimination in systemic terms is the most fundamental challenge that disability human rights law currently faces. Achieving fundamental change in relation to disability at work necessitates challenging able-bodied norms. To that end, a social construction of disability entails adapting the environment to meet the needs of those with a variety of disabilities. Tackling disability discrimination requires contesting what is deemed "normal" because it is the way most able-bodied persons function, necessitating a thorough understanding of adverse effects discrimination, which looks behind purportedly neutral practices to uncover detrimental effects on those who do not function "normally".

The fact that some disabilities preclude some kinds of work should not be extended to create employment barriers beyond what is warranted, requiring stringent assessments of bona fide occupational requirements ("BFOR"). The duty to accommodate is now part of the BFOR defence. Accommodation is about making adjustments (exceptions) to rules. If the rule is wholly invalid, one does not reach the stage of adjustment, one simply invalidates the rule. The duty to accommodate in the BFOR test should be seen as subsidiary to the overarching concept of "reasonably necessary". In moving to the duty to accommodate, it is still important to think in both systemic as well as individualized terms. A systemic approach to accommodation anticipates the need for individualized accommodation, and builds in the necessary flexibility from the outset. Examples of innocent absenteeism are used to elaborate on the notion of systemic accommodation. In different settings, other recent examples blurring the distinction between the prima facie case of discrimination and the BFOR are problematic because such blurring weakens the scrutiny of respondents' justificatory arguments.

Full integration of disabled workers largely depends on the extent to which systemic approaches to disability discrimination can be incorporated into anti-discrimination law.

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INTRODUCTION

The last few decades have featured numerous developments in human rights law. Their impact on the workplace has been significant, especially in relation to disability. A quarter century ago, disability barely made the radar screen of anti-discrimination law in employment. Currently, it occupies centre stage.

Disability as a ground of prohibited discrimination is noteworthy for its immense diversity. Simplistic solutions to disability discrimination will not do. But it does not follow that disability is a purely individualized phenomenon requiring purely individualized solutions. Approaching disability discrimination in systemic terms is the most fundamental challenge that disability human rights law currently faces. Hence, the development of such an approach is the theme of this article.

Disability as a prohibited ground of discrimination in the workplace is also noteworthy for the fact that particular kinds of disabilities do preclude certain kinds of work. As someone who has never seen well enough to be able to drive, I could never aspire to be a bus driver. But the fact that some disabilities preclude some kinds of work should not be extended to create employment barriers beyond what is warranted. Thus, the development of stringent assessments of bona fide occupational requirements ("BFOR") has been especially important in relation to disability. Moreover, the development of the duty to accommodate has been crucial to the capacity of the workplace to respond to the diverse circumstances of disabled workers. However, the law has only just begun to tackle BFOR analyses and the duty to accommodate in systemic terms.

This article proceeds as follows. First is a brief historical overview of the incorporation of disability as a prohibited ground of discrimination into human rights law. Next are comments on the meaning of disability as a prohibited ground and elaboration on how a proper understanding of disability has the capacity to challenge able-bodied norms. Then follows a discussion of adverse effects discrimination and its importance to the identification of disability discrimination. The fourth section is an analysis of the scope of a systemic approach to BFOR standards and the duty to accommodate. Aspects of the law on innocent absenteeism are used as a specific example. Finally, concerns are raised about the stringency of the BFOR analysis being weakened by some recent examples where judges and adjudicators conflated the prima facie case of discrimination and the BFOR stages of analysis. The theme maintained throughout, and reiterated in the conclusion, is the need to move beyond an ad hoc approach to tackling disability discrimination.

I
DISABILITY AS A GROUND OF DISCRIMINATION

Disability as a ground of discrimination was a late addition to both the *Canadian Charter of Rights and Freedoms*[1] and to human rights legislation. Physical and mental disability were added as enumerated grounds to the section 15 equality rights provision of the *Charter* at the eleventh hour.[2] As regards to human rights legislation, New Brunswick, by virtue of a 1976 amendment to the *Human Rights Act*, became the first Canadian jurisdiction to add "physical disability" as a listed ground of prohibited discrimination.[3] However, it was not until 1985 that

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[1] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (U.K.), 1982, c. 11 [*Charter*].

[2] Physical and mental disability were added to the draft of the *Charter* on 13 February 1981: Anne. F. Bayefsky, "Defining Equality Rights" in Anne F. Bayefsky & Mary Eberts, eds., *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985) 1 at 10.

[3] *Human Rights Act*, R.S.N.B. 1973, c. H-11, as am. by S.N.B. 1976, c. 31, s.1. British Columbia's first human rights legislation, *Human Rights Code of British Columbia Act*, S.B.C. 1973, c. 119, had the potential to

New Brunswick added "mental disability".[4] At the federal level, "physical handicap" was included in "matters related to employment" when the *Canadian Human Rights Act* was first passed in 1977.[5] Although the more general term "disability" replaced "physical handicap" in 1983,[6] the remedial bar on mental disability complaints under the *Canadian Human Rights Act* was not removed until April 17, 1985 (the date of coming into force of section 15 of the *Charter*).[7] The incorporation of disability into human rights legislation was even slower in other provinces. For example, in what was then the *Individual's Rights Protection Act*, Alberta first introduced the term "physical characteristics" in 1980,[8] changing it to "physical disability" in 1985;[9] it was not until 1990 that mental disability was added.[10] In Nova Scotia, "physical handicap" was added to the *Human Rights Act* in 1980,[11] and then changed to "physical or mental disability" in 1986.[12]

Despite the slow start, over the last quarter century there has been a significant change in the legal landscape of workplace disability discrimination. Jurisprudence arising from both labour arbitration and human rights tribunals has advanced the rights of disabled workers.[13] Rulings from the Supreme Court of Canada prohibit the contracting out of human rights legislation[14] such that collective agreements must be interpreted so as to conform to human rights legislation.[15] These rulings have made labour arbitration a prominent forum for the development of anti-discrimination law. However an important limitation of labour arbitration that has significant consequences for disability law is that, by its very nature, labour arbitration deals solely with workers who are already employed; administration of collective agreements amounts to an ineffective means of dealing directly with those who, because of a disability, face barriers to getting hired in the first place. Only if labour arbitration produces systemic change can it be expected to have spill-over effects at the hiring stage. Furthermore, since most Canadian employ-

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cover disability discrimination because, uniquely in Canada, British Columbia did not initially have a closed list of prohibited grounds of discrimination. Instead, s. 8(1) prohibited, *inter alia*, employment discrimination without "reasonable cause". Section 8(2)(a) specified that listed grounds, not including disability, did not constitute reasonable cause. When British Columbia switched to the dominant mode of a closed list of prohibited grounds in replacement legislation "physical and mental disability" were included in the closed list: *Human Rights Act*, S.B.C. 1984, c. 22, s. 8.

[4] *Human Rights Act*, R.S.N.B. 1973, c. H-11, as am. by S.N.B. 1985, c. 30, s. 7.

[5] *Canadian Human Rights Act*, S.C. 1976-77, c. 33, s. 3; s. 41(4) of that statute nonetheless imposed severe limitations in respect of remedies for physical handicap complaints.

[6] *Canadian Human Rights Act*, S.C. 1976-77, c. 33, as am. by S.C. 1980-81-82-83, c. 143, s. 2. By virtue of s. 25 of the 1983 amendment, the limitations on remedies for disability complaints in s. 41(4) were reduced. These special remedial limitations for disability (consolidated as s. 53(4) in *Canadian Human Rights Act*, R.S.C. 1985, c. H-6) were retained until S.C. 1998, c. 9, s. 27.

[7] See *Canadian Human Rights Act*, S.C. 1976-77, c. 33, as am. by S.C. 1980-81-82-83, c. 143, s. 25.

[8] *Individual's Rights Protection Amendment Act*, S.A. 1980, c. 27, s. 2.

[9] *Individual's Rights Protection Act*, R.S.A. 1980, I-2, as am. by S.A. 1985, c. 33, s. 2.

[10] *Individual's Rights Protection Act*, R.S.A. 1980, I-2, as am. by S.A. 1990, c. 23, s. 3.

[11] *Human Rights Act*, S.N.S. 1969, c. 11, as am. by S.N.S. 1980, c. 51, s. 1.

[12] *Human Rights Act*, S.N.S. 1969, c. 11, as am. by S.N.S. 1986, c. 49, s. 1.

[13] See generally Michael Lynk, "Disability and Work: The Transformation of the Legal Status of Employees with Disabilities in Canada" in The Hon. R.S. Echlin & C. Paliare, eds., *Law Society of Upper Canada Special Lectures 2007: Employment Law* (Toronto: Irwin Law, 2007) 189. At 244-254, Lynk states that wrongful dismissal actions have not been a fruitful source for the development of anti-discrimination law in relation to disability. I agree with Lynk, however, I do not think it is realistic to expect that a cause of action that accepts the right to fire, as long as enough money is paid, can be very helpful in detailing the conditions enabling persons with disabilities to continue to work.

[14] *Ontario Human Rights Commission v. Etobicoke (Borough of)*, [1982] 1 S.C.R. 202, 95 D.L.R. (4th) 577 [*Etobicoke* cited to S.C.R.].

[15] *Central Okanagan School District No. 23 v. Renaud*, [1992] 2 S.C.R. 970; *Parry Sound (District) Social Services Administration Board v. O.P.S.E.U., Local 324*, 2003 SCC 42, [2003] 2 S.C.R. 157.

ees are not unionized,[16] and thus not covered by a collective agreement, the majority of the workforce cannot benefit directly from labour arbitration decisions.

Moreover, it would be naïve to assume that legal changes are easily incorporated into the day-to-day reality of the world of work. Despite the impressive volume of human rights tribunal decisions and labour arbitration awards determining the rights of disabled workers, it is impossible to know how many such cases never even get off the ground. It is not an easy decision to seek legal redress against perceived discrimination even if—often a big if—a complainant anticipates being able to prove discrimination. Especially at the hiring stage, it is easy for an employer to mask a refusal to hire that is grounded in disability by rationalizing it as something entirely different.

The expectation of a negative reaction to disability is still pervasive enough that a recent Ontario human rights tribunal adjudicator, David Mullan, ruled that an employer could not justify a termination based on the fact that a complainant, before being hired, had been untruthful in concealing his bipolar disorder.

> I reject the argument that ADGA had the right to dismiss Mr. Lane once it discovered that he had lied about his bipolar condition in the course of the hiring process or, at the very least, had failed to reveal a factor that was critical to any determination that he was qualified to perform the job for which he was being considered. The expert evidence of Philip Upshall established why it was that those with bipolar disorder are extremely reluctant to reveal their disorder to prospective employers. In the particular case, this was manifest in the testimony of both Mr. Lane and Ms. Lane as they revealed the anguish that Mr. Lane had gone through in deciding if and when to reveal his condition to his employer both at ADGA and earlier at Siemens and Linmor. The perception, supported by the testimony of Mr. Upshall, was that to reveal this information at a job interview would trigger in most employers a stereotypical reaction to someone with a mental illness leading to a decision not to hire. In those circumstances, I am not prepared to find that ADGA could rely on Mr. Lane's lying as an independent basis for dismissal and thereby avoid having to account for its treatment of him as someone exhibiting the symptoms of bipolar disorder in the workplace.[17]

For those with visible disabilities, hiding the fact of a disability from potential employers is not an option.

Although it is important to retain some skepticism about the effectiveness of legal rights, the change in legal landscape has certainly altered the workplace environment. The remainder of this article will explore the extent of legal change brought about by prohibiting workplace disability discrimination. The underlying question is whether the change is marginal or fundamental.

II

Meaning of Disability

The most critical element in achieving fundamental change in relation to disability at work is challenging able-bodied norms. It is a trifling improvement if the prohibition against disability discrimination means nothing more than protecting the disabled so long as they perform like the able-bodied (i.e., if it means nothing more than formal equality). Substantive equality, which accounts for difference, is especially important in relation to disability equality because disability frequently requires a manner of job performance that differs from that of the able-bodied.[18]

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[16] Donald D. Carter *et al.*, *Labour Law in Canada*, 5th ed. (Markham, Ontario: Butterworths, 2002) at 60.

[17] *Lane v. ADGA Group Consultants Inc.*, 2007 HRTO 34, 61 C.H.R.R. 307 at para. 137 [*Lane*].

[18] See Richard Devlin & Dianne Pothier, "Introduction: Toward a Critical Theory of Dis-Citizenship" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: UBC Press, 2006) 1.

For the prohibition against disability discrimination to actually advance human rights, it is essential to move beyond a bio-medical model of disability. Using a bio-medical model means locating the disability within the individual, with a focus on "fixing" the individual to fit the environment. In contrast, a social model of disability entails a focus on changing or adapting the environment to meet the needs of those with a variety of disabilities.

> Policy from this [human rights] perspective constructs an analysis of how society marginalizes people and how society can be adjusted to respond more effectively to the presence and needs of those who have been systemically marginalized. Treating the disadvantage is postulated as being the reformulation of social and political policy. Prevention is effected through recognizing the condition of disability as inherent to society. It is presumed that people with disabilities are an inherent part of society, not some kind of anomaly to normalcy.[19]

Where the presence of a disability is not contested, it is frequently the case that decisions concerning workplace disability discrimination do not make the distinction between a bio-medical and a social construction of disability. Thus the implications of that distinction for understanding and remedying disability discrimination are often not explored.

Where the meaning of disability has been challenged, however, the Supreme Court of Canada has been prepared to at least partially incorporate a social model of disability by adopting a broad interpretation of disability that enables human rights legislation to offer significant job protection.[20] In *Montreal and Boisbriand* the Supreme Court of Canada ruled that "handicap" in Quebec human rights legislation did not require actual functional limitations and included perceptions of disability.[21] These holdings are crucial to the recognition that disability discrimination is about the social construction of disability (i.e., about assumptions related to the capacity to perform work based on non-disabled [able-bodied] norms). In *Montreal and Boisbriand* individuals with no current functional limitations were either fired or not hired because of anticipated problems; the employers in these cases were engaging in a pre-emptive strike to avoid future disability issues. In a previous article, I have commented in support of the Supreme Court of Canada's decision:

> What was especially objectionable was that the employees were fired or not hired because the employers had such an extreme pre-occupation with normalcy that they wanted to be rid of someone who *might* have a "real" disability in the future. One of the purposes of a prohibition against disability discrimination is to counter that pre-occupation with normalcy. Understanding the threat to equality for persons with disabilities entails recognizing that people who in some sense are not "normal" are more vulnerable to being excluded. In order to fulfil the purpose of challenging the premium on normalcy, "perception" of disability needs to be subsumed in the category of "disability" or "handicap."[22]

The jurisprudence is just starting to sort out the implications of a social model of disability.

Nonetheless, it is important that perceptions of disability not be so elastic as to lose the connection to challenging able-bodied norms. In a recent Ontario case, *Weyerhaeuser Co. v. Ontario (Human Rights Commission)*,[23] the Divisional Court set aside a human rights tribunal's ruling rejecting a preliminary objection from the employer. The complainant had his conditional offer of employment withdrawn after he tested positive for marijuana. He ultimately admitted to

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[19] Marcia H. Rioux & Fraser Valentine, "Does Theory Matter? Exploring the Nexus between Disability, Human Rights and Public Policy" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: UBC Press, 2006) 47 at 52.

[20] *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, 2000 SCC 27, [2000] 1 S.C.R. 665 at paras. 72-81 [*Montreal and Boisbriand*].

[21] *Ibid.* at para. 71.

[22] Dianne Pothier, "Connecting Grounds of Discrimination to Real People's Real Experiences" (2001) 13 C.J.W.L. 37 at 48.

[23] 2007 C.L.L.C. 230-012, 279 D.L.R. (4th) 480.

occasional recreational use of marijuana,[24] but did not claim addiction so as to amount to a disability. The Divisional Court ruled that, even on a preliminary motion, there was no tenable basis on the facts to go to a hearing on a claim that the employer had discriminated based on a perceived disability. In a similar case from Alberta, the Court of Appeal ruled that a positive pre-employment drug test resulting in the termination of a recreational user of marijuana could not found a successful disability discrimination claim.[25] While it may be true that some recreational users of marijuana might have an addiction that they do not recognize, it would strain credulity to say that all persons who smoke marijuana are addicts and thus have a disability. To enable non-addicts to ride on the disability band-wagon would distort the objectives underlying the protections against disability discrimination. Irrespective of one's view on how occasional recreational use of marijuana might relate to job performance, such use is not pertinent to the issues of disability or discrimination on the basis of disability. To stretch the meaning of disability this far would undermine the purpose of prohibiting disability discrimination, which is to challenge able-bodied norms.

For similar reasons, the Supreme Court of Canada concluded in *Montreal and Boisbriand*, in obiter, that "normal" ailments of the able-bodied "will generally not constitute" a handicap or disability.[26] Justice L'Heureux-Dubé reasoned that "[t]here is not normally a negative bias against these kinds of characteristics or ailments" and that under human rights legislation "the emphasis is on obstacles to full participation in society ... "[27] In order for human rights legislation to have a transformative impact, there must be an emphasis on systemic barriers. On the rare occasion that a normal ailment has detrimental consequences, it is acceptable to invoke disability discrimination for an individual case.[28] However, such cases should not divert the focus of human rights protections against disability discrimination toward trivial examples.

The law needs to concentrate on the bigger picture and on determining the serious obstacles to inclusion. To do so requires integrating the social construction of disability into the analysis. The social construction of disability not only impacts the meaning of disability, but also the meaning of discrimination and the means of remedying discrimination. The manner in which individual and systemic elements of tackling disability discrimination intertwine has implications far beyond the definition of disability.

III
ADVERSE EFFECTS DISCRIMINATION

Intentional or direct discrimination on the basis of disability is certainly part of what human rights legislation is designed to combat.[29] Nonetheless, a substantial portion of disability dis-

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[24] *Ibid.* at para. 7 (Weyerhaeuser claimed that its withdrawal of the offer of employment was not due to the positive drug test itself, but rather because Chornyj initially lied about his use of marijuana).

[25] *Alberta (Human Rights and Citizenship Commission) v. Kellogg Brown & Root (Canada) Co.*, 2007 ABCA 426, 425 A.R. 35, leave to appeal to S.C.C. refused, 460 A.R. 179 (The Human Rights Panel had rejected the discrimination claim, but the decision was set aside by the chambers judge. The Court of Appeal allowed the appeal, restoring the decision of the Human Rights Panel to dismiss the complaint. The Court of Appeal noted, at para. 43, that " ... the issue of how the KBR drug testing policy affected drug addicted persons generally was not before the panel.").

[26] *Montreal and Boisbriand*, *supra* note 20 at para. 82.

[27] *Ibid.*

[28] See Walter S. Tarnopolsky & William Pentney, *Discrimination and the Law* looseleaf (Toronto: Thomson, 2004) at c. 7A-12-14. Although Pentney criticizes L'Heureux-Dubé J. as being "simplistic" for saying that those with normal ailments could "never" suffer from disability discrimination (at c. 7A-12), she did not actually say "never". She said that normal ailments "generally" do not constitute a handicap.

[29] Judith Mosoff, "Is the Human Rights Paradigm 'Able' to Include Disability: Who's In? Who Wins? What? Why?" (2000) 26:1 Queen's L.J. 225.

crimination is adverse effects discrimination, that is, discrimination without express reference to any disability, but still creating barriers for those with disabilities.

> A distinction must be made between what I would describe as direct discrimination and the concept already referred to as adverse effect discrimination in connection with employment. Direct discrimination occurs in this connection where an employer adopts a practice or rule which on its face discriminates on a prohibited ground. For example, "No Catholics or no women or no blacks employed here." ... On the other hand, there is the concept of adverse effect discrimination. It arises where an employer for genuine business reasons adopts a rule or standard which is on its face neutral, and which will apply equally to all employees, but which has a discriminatory effect upon a prohibited ground on one employee or group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other members of the work force.[30]

The fundamental challenge of tackling disability discrimination is to contest what is deemed "normal" because it is the way most able-bodied persons function. That is not possible without a thorough understanding of adverse effects discrimination, which requires looking behind purportedly neutral rules or practices to uncover detrimental effects on those who do not function "normally".

The initial recognition of adverse effects discrimination developed not in the context of disability discrimination, but rather religious discrimination. When the Supreme Court of Canada subsumed adverse effects discrimination within prohibited discrimination under Canadian human rights legislation in *O'Malley*,[31] however, the implications for disability discrimination were obvious. A challenge by religious minorities to dominant religious or secular norms has clear parallels with a challenge by the disabled to norms based on able-bodied modes of performance. It was not mere happenstance that the Canadian Association for the Mentally Retarded and the Coalition of Provincial Organizations of the Handicapped were interveners in *O'Malley*. Employment rules or expectations formulated in accordance with the able-bodied way of doing things are quite likely to exclude disabled workers, even if unintentionally.

Since *Meiorin*,[32] the analytical approach following a finding of a prima facie case of discrimination no longer differentiates between direct and adverse effects discrimination. Yet, the concept of adverse effects discrimination is still crucial to a comprehensive understanding of discrimination. One can no longer avoid a finding of a prima facie case of discrimination by claiming that one is relying on the normal way of doing things or applying typical expectations. Where there is no express reference to grounds so as to constitute direct discrimination, adverse and/or disproportionate effects must still be assessed as a means of challenging norms.

A key legal concept enabling norms to be challenged is the duty to accommodate up to the point of undue hardship, herein the duty to accommodate. Like adverse effects discrimination, the duty to accommodate, though initially recognized in the context of religious discrimination, is especially important in relation to disability discrimination. Although the duty to accommodate is no longer exclusively linked to adverse effects discrimination,[33] its conceptual underpinnings are heavily influenced by the fact that it emerged coincidentally with the recognition of

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[30] *Ontario Human Rights Commission and O'Malley v. Simpson-Sears Ltd.*, [1985] 2 S.C.R. 536 at 551, 52 O.R. (2d) 799 [*O'Malley* cited to S.C.R.].

[31] *O'Malley*, *ibid.* (*O'Malley* involved an ultimately successful claim of religious discrimination arising from the requirement for full-time sales clerks of a retail store to work on Saturdays. Although the rule applied to all full-time sales clerks, it had a disproportionate impact on practicing Seventh Day Adventists, like O'Malley, whose religious tenets precluded work on Saturdays.).

[32] *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 S.C.R. 3, 176 D.L.R. (4th) 1 [*Meiorin* cited to S.C.R.] (*Meiorin* involved a challenge to an aerobic fitness standard for forest firefighters. The standard was gender neutral on its face, and hence did not amount to direct discrimination, but because the standard disproportionately excluded women, it did amount to adverse effects discrimination.).

[33] *Ibid.*

adverse effects discrimination in *O'Malley*.[34] When the Supreme Court of Canada accepted that Canadian human rights legislation prohibited more than intentional or direct discrimination, it simultaneously recognized the need to put some implicit limits on adverse effects discrimination. Without an express link to the grounds of discrimination limiting the scope of prohibited discrimination, the incorporation of adverse effects discrimination substantially expanded what may amount to prima facie discrimination. Undue hardship, a respondent's defence to its duty to accommodate, ensured that not all disproportionate impact would be deemed illegal. As it initially emerged in *O'Malley* as an element of adverse effects discrimination, the duty to accommodate was a very individualized concept. In my assessment, which I develop below, an exclusively individualized understanding of the duty to accommodate is woefully inadequate.

IV

THE BFOR AND THE DUTY TO ACCOMMODATE

When the Supreme Court of Canada first incorporated the duty to accommodate into Canadian human rights law in *O'Malley*, it was expressly understood as involving individualized exceptions to rules, where the legitimacy of such rules was not seriously in doubt.[35] Although adverse effects discrimination was incorporated, its impact was assumed to be limited to ad hoc minor tinkering through the duty to accommodate.

In another religious discrimination case, *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, the majority judgment of Justice Wilson continued this exclusively individualized approach to the duty to accommodate.[36] A lot of attention has been paid to the difference between the majority judgment in *Central Alberta Dairy Pool*, which held that the duty to accommodate arose in adverse effects discrimination cases outside any bona fide occupational requirement/qualification ("BFOR/Q") defence, and the minority judgment of Justice Sopinka (Justices McLachlin and La Forest concurring), which subsumed the duty to accommodate within the BFOR/Q.[37] On that point, nine years later the minority ultimately carried the day in Justice McLachlin's unanimous judgment in *Meiorin,* adopting a unified approach to both direct and adverse effects discrimination.[38] However, there is another important distinction between the majority and minority judgments in *Central Alberta Dairy Pool* which remains pertinent and yet unresolved in *Meiorin*. While Justice Sopinka agreed in *Central Alberta Dairy Pool* that ad hoc accommodation was one way a respondent could avoid liability for discrimination, he also suggested an alternative:

> An employer with a large number of employees of many different religions may be able to discharge the duty inherent in the BFOQ by adopting a policy with respect to the accommodation of the religious beliefs of its employees. Such a policy may be a reasonable alternative to a practice that entails an *ad hoc* accommodation of individual employees.[39]

Although Justice Sopinka did not elaborate, there is at least a hint here that he was contemplating accommodation in more systemic terms.

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[34] *Supra* note 30.

[35] *Ibid.* at 552. In *O'Malley*, the general rule was that all full-time clerks were required to work some Saturdays. Given the propensity for shoppers to shop on Saturdays, no one was challenging the need for Simpsons-Sears to have sales clerks working on Saturdays.

[36] [1990] 2 S.C.R. 489 at 516, 72 D.L.R. (4th) 417 [*Central Alberta Dairy Pool* cited to S.C.R.] (The case involved the dismissal of an employee because of his absence from work on one particular day of religious significance to the employee. The employer did not accept that non-attendance at work for religious reasons was a legitimate excuse for absence.).

[37] Brian Etherington, "Central Alberta Dairy Pool: The Supreme Court of Canada's Latest Word on the Duty to Accommodate" (1993) 1 Canadian Labour Law Journal 311 at 320-24.

[38] *Supra* note 32 at para. 50.

[39] *Central Alberta Dairy Pool, supra* note 36 at 529. See also Etherington, *supra* note 37 at 322.

That hint is also picked up in *Meiorin* where the Court critiqued an approach to accommodation that does not acknowledge systemic discrimination.[40] However, that focus is not sustained throughout the entire judgment. *Meiorin* identifies the need to investigate alternative standards,[41] and to build accommodation into the workplace standard, but the judgment still labels these responses as individual accommodation.[42] The link between individualized accommodation and combating systemic discrimination is not further developed. In what follows, I explore that link, after laying some preliminary groundwork.

Meiorin is still the leading authority on the issue of where the duty to accommodate fits into a discrimination analysis. *Meiorin* adopts a unified approach to a BFOR, equally applicable to both direct and adverse effects discrimination, and articulates a stringent BFOR test. The duty to accommodate is incorporated into the third step of the

> ... three-step test for determining whether a prima facie discriminatory standard is a BFOR. An employer may justify the impugned standard by establishing on the balance of probabilities:
>
> (1) that the employer adopted the standard for a purpose rationally connected to the performance of the job;
>
> (2) that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
>
> (3) that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.[43]

Donald Carter, shortly after *Meiorin* was released, drew the following implications:

> The emphasis in *Meiorin* on the content of workplace standards has important implications for grievance arbitration. Longstanding rules and practices established pursuant to a collective agreement may be vulnerable to challenge. Even more important, perhaps, is the fact that arbitrators no longer have the option of upholding a collective agreement provision while allowing an exception as a vehicle for accommodating an employee who has suffered adverse-effect discrimination.[44]

Although Carter is technically accurate, I am not persuaded there is a substantive difference between upholding a collective agreement provision, while allowing an exception not provided in the agreement, compared to invalidating the agreement to the extent of reading in an exception. The more fundamental implications of *Meiorin* stem from the question of where, and in what ways, BFORs are founded on exceptions. *Meiorin* itself is somewhat obscure on these issues.

There are passages in *Meiorin* which suggest that consideration of the duty to accommodate short of undue hardship is always part of a BFOR analysis.[45] However, these passages are inconsistent with both the remainder of the *Meiorin* judgment and its underlying principle.[46] Although it is clear that employers will fail the third step of the test if they have not accommodated up to the point of undue hardship, the full analysis in *Meiorin* leads to the conclusion that employers could fail the third step of the test even before consideration of accommodation arises. Accommodation is about making adjustments (exceptions) to rules or standards. If the rule or standard is wholly invalid, one does not reach the stage of adjustment, one simply invalidates the rule. Before *Meiorin*, invalidation had been the assumed result in cases of direct discrimina-

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[40] *Supra* note 32 at para. 41.

[41] *Ibid.* at para. 65.

[42] *Ibid.* at para. 68.

[43] *Ibid.* at para. 54.

[44] Donald Carter, "The Arbitrator as Human Rights Adjudicator: Has *Meiorin* Made a Difference?" in Kevin Whitaker *et al.*, eds., *Labour Arbitration Yearbook 2001-2002* (Toronto: Lancaster House, 2002) 1 at 6.

[45] *Supra* note 32 at paras. 62, 67.

[46] *Ibid.* at paras. 40-41.

tion.[47] After *Meiorin*, wholly invalidating the standard can result from assessing either direct or adverse effects discrimination.[48] Thus the duty to accommodate in step three of the BFOR test should be seen as subsidiary to the overarching concept of "reasonably necessary."

"Reasonably necessary" in *Meiorin* should be understood as a stringent test of justification that starts with an overall assessment of the challenged rule or practice.[49] One should not jump to tinkering around the edges without first subjecting the general rule and its underlying premises to careful scrutiny. If the rule or practice reflects dominant and discriminatory norms, and is applied merely because it reflects "the way things have always been done", without any underlying justification, then it will fail the "reasonably necessary" test before any consideration of accommodation.

Take for example an employment rule that says the job must be performed while standing. The rule is challenged by someone using a wheelchair. Assume there is actually nothing about the workplace or the job that hinges on whether the job is performed from a standing or seated position. In other words, there is no sense at all in which the standing rule is reasonably necessary. In such a scenario, the rule should simply be struck down, without any need to canvass the duty to accommodate. That would leave all employees with the choice of performing the job standing or seated, irrespective of whether they have a disability which either precludes standing or makes it difficult to stand. Since a primary purpose of prohibiting disability discrimination is to challenge able-bodied norms, the first line of inquiry should be whether the norm can be disregarded altogether, without any need to consider exceptions. That is an essential first inquiry if systemic discrimination is to be challenged. Moreover, if a contemplated exception challenges the logic of the rule, it is the rule itself that should be under scrutiny. As I have argued elsewhere, that was the situation in *Meiorin*, though that point was not highlighted in the judgment.[50]

Nonetheless, given the variety of disabling conditions, it is often the case that the same rules, standards, or practices do not and cannot work for everyone. As such, accommodation, in the sense of adjustments or exceptions, must be considered in cases of alleged disability discrimination. In moving to the consideration of the duty to accommodate, however, it is still important to think in both systemic as well as individualized terms. That is precisely the point of assessing building codes and design standards based on universal design principles. The Canadian Human Rights Commission has elaborated: "Universal Design, Design for All and Inclusive Design all provide guiding principles that promote design that considers the needs of everyone. These principles seek to create an environment that is usable by the greatest number of users ... "[51]

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[47] *O'Malley*, *supra* note 30 at 552; *Meiorin*, *supra* note 32 at para. 30.

[48] *Meiorin*, *supra* note 32 at para. 31.

[49] See Colleen Sheppard, "Of Forest Fires and Systemic Discrimination: A Review of *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*" (2001) 46 McGill L.J. 533 at 550-53; Ravi Malhotra, "The Legal Genealogy of the Duty to Accommodate American and Canadian Workers With Disabilities: A Comparative Perspective" (2007) 23 Wash. U.J.L. & Pol'y 1 at 16.

[50] Dianne Pothier, "BCGSEU: Turning a Page in Canadian Human Rights Law" (1999) 11 Const. Forum Const. 19 at 23:

> If the logic of the rule and the logic of the challenge to the rule directly contradict each other, an exception to the rule makes no sense because any exception undermines the basis of the rule. That was precisely the situation in *BCGSEU* [*Meiorin*]. The employer's rationale for the aerobic fitness test was safety. The basis for the union's challenge to Tawney Meiorin's dismissal was that she could safely perform the job in spite of having failed the aerobic fitness test, i.e. that the test was not an accurate gauge of safety.

[51] Canadian Human Rights Commission, *International Best Practices in Universal Design: A Global Review* (Ottawa: Government of Canada, Revised Edition August 2007) at 1, online: CHRC <www.chrc-ccdp.ca/pdf/bestpractices_en.pdf>.

Consider a revised version of the previous example. Assume the reason for the standing rule is that the job involves operating equipment that is designed to be used while standing. Thus the rule makes some sense in general, but not in a way that can be conclusive overall. The accommodation question is whether the equipment can be modified or adjusted so as to be operated from a seated position. *When* one asks that question matters a great deal. If accommodation is merely ad hoc and individualized, that question is asked after the fact, at which point equipment modification may be very difficult, potentially invoking undue hardship. In contrast, a systemic approach to accommodation would ask the question before the fact, and build into the initial design of the equipment a relatively easy means of adjusting the mode of operation from a standing to a seated position. Similarly, the ease of generating alternate format versions of printed documents (such as large print or Braille, or compatibility with a voice synthesizer) depends on the way in which the document was first created. Wendy Bailey describes a design method that envisages disability concerns throughout:

> Universal design is a revolutionary method of design process that fully supports the social model of disability. Universal design … seeks to design all products, buildings and interiors to be used by all people to the greatest extent possible regardless of their physical abilities. The result of this method of design is the seamless incorporation of accommodations that do not call attention to impairment as being a unique experience.[52]

Thus a systemic approach to accommodation anticipates the need for individualized accommodation, and builds in the necessary flexibility from the outset. "There is no claim to universal design's ability to eliminate 'design for special needs' entirely but rather: eliminate it to a greater extent than if the needs of impairment are excluded from design process entirely … "[53] The broader implications of a systemic approach to accommodation include the recognition that individual employers alone cannot comprehensively transform the work environment. Human rights adjudication and labour arbitration based on complaints and grievances—even systemic ones—against individual employers have significant limits. But even within the confines of individual employers, much still remains to be done in order to move toward a more systemic approach to accommodation.

A systemic approach to accommodation challenges able-bodied norms by contemplating diversity from the start. Ad hoc individualized accommodation contemplates "disability specific needs as a segregated thought rather than an inclusive thought".[54] In contrast, systemic accommodation is founded on "inclusive thought". Such contemplation gives the duty to accommodate the potential to be genuinely transformative in challenging able-bodied norms, instead of limiting it to ad hoc minor modifications. Although this distinction is not inconsistent with *Meiorin*, it is not clearly drawn out in the judgment.

Nor has the notion of systemic accommodation been significantly developed since *Meiorin*. The thrust of the duty to accommodate and the remedies flowing from a failure to accommodate up to the point of undue hardship, remain focused on the individual claimant. Progress toward a systemic approach has been modest. For example, in *Lane*, where an employer's "rush to judgment"[55] concluded that Lane's bipolar disorder could not be accommodated, Adjudicator Mullan found a breach of the procedural aspect of the duty to accommodate. This ruling provided financial compensation for Lane.[56] Mullan then turned to "public interest remedies" for the em-

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[52] Wendy Bailey, *Disability and Universal Design*, online: SNOW: Special Needs Ontario Window <http://snow.utoronto.ca/index.php?option=com_content&task=view&id=409&Itemid=380>.

[53] *Ibid.*

[54] *Ibid.*

[55] *Supra* note 17 at para. 145.

[56] *Ibid.* at paras. 153-163, 165 (neither the Commission nor Lane sought reinstatement).

ployer's "egregious"[57] lack of attention to its legal obligations under human rights legislation. In light of the absence of workplace policies, Mullan ordered the following:

> (6) The Respondent shall retain at its own expense a qualified consultant (approved by the Commission) to provide training to all employees, supervisors, and managers on the obligation of employers under the Code and, in particular, the accommodation of persons with disabilities with a special focus on mental health issues.
>
> (7) The Respondent shall within three months of this Order establish a comprehensive written anti-discrimination policy that conforms with the requirements of the Code, and that addresses discrimination on the ground of disability.
>
> (8) The Respondent shall post the policy ordered under (7) in plain and obvious locations at all places where the Respondent does business and will include the policy in the orientation materials that it provides to new employees.
>
> (9) The Respondent shall also provide copies of the policy ordered under (7) as part of any request for proposal.[58]

There was no further discussion regarding public interest remedies. These orders are clearly boiler plate terms. The absence of any elaboration suggests that, although systemic accommodation is acknowledged, there is no real follow-through.

A. Innocent Absenteeism

I want to further explore the connections among individualized accommodation, systemic accommodation, and challenging able-bodied norms by reference to some aspects of "innocent absenteeism". The concept of innocent absenteeism long pre-dates statutory prohibitions on disability discrimination. Thus, in 1993, Innis Christie was able to write an extensive article about arbitral jurisprudence concerning innocent absenteeism, while leaving disability discrimination issues to another author in the same volume.[59] It is now clear that the law of innocent absenteeism has been affected significantly by prohibitions in human rights legislation against disability discrimination. Michael Lynk has summarized the change as follows:

> In traditional employment law, an employer had just cause to terminate an employee for innocent absenteeism when two standards were met: (1) the employee's past record of absenteeism was excessive; and (2) there was no reasonable prognosis for improvement. In the classical language of employment law, the employment contract was frustrated for non-blameworthy reasons. The arrival of the accommodation duty has expanded and transformed the test in the labour arbitration arena. Now, in addition to these two traditional standards, an employer must also establish two further criteria: (3) the employee had been warned that her absenteeism was excessive, and that failure to improve could result in dismissal; and (4) if the absenteeism is the result of a disability, then accommodation efforts to the point of undue hardship have to be extended to the employee.[60]

What does the duty to accommodate up to the point of undue hardship mean in the context of innocent absenteeism? The following briefly explores that question under two circumstances: last chance agreements and automatic termination clauses.

B. Last Chance Agreements

In instances of innocent absenteeism, it is frequently the case that an employee is retained in his or her job or reinstated to his or her job on individualized terms and conditions related to future attendance at work. Such situations may arise by agreement as a means of avoiding arbi-

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[57] *Ibid.* at para. 164.

[58] *Ibid.* at para. 165.

[59] Innis Christie, "The Right to Dismiss for Innocent Absenteeism: An Arbitrator's Perspective" in William Kaplan, Jeffrey Sack, & Morley Gunderson, eds., *Labour Arbitration Yearbook 1993* (Toronto: Lancaster House, 1993) 201.

[60] Lynk, *supra* note 13 at 240.

tration. They may also arise from the arbitration of a dismissal and the ensuing award of the arbitrator. In either case, such terms and conditions are commonly referred to as last chance agreements.[61] There are numerous issues surrounding last chance agreements; only one will be discussed here.

It is common practice in last chance agreements to specify future attendance requirements by reference to some average attendance record of co-workers. Arguments have been made about the proper way of calculating such an average.[62] However, there is a more fundamental issue in referencing averages at all. Unless the distribution is absolutely flat, there will always be employees whose attendance records fall below average, but that does not necessarily mean there is any actual problem with below average attendance. Even if everyone's attendance record is unproblematic, there will almost inevitably be some who fall below average. Why should below average attendance be accorded such particular significance?

More fundamentally, the measurement of average attendance represents an attempt to identify a single norm for the workplace, which is at odds with the premise of prohibiting disability discrimination. If the point is to challenge norms, a statistical means of establishing a single norm is inconsistent. There is no reason to assume any connection between below average attendance records and undue hardship. Thus, to be valid, future attendance requirements in last chance agreements need to be geared instead to absenteeism that creates an operational disruption to the workplace sufficient to constitute undue hardship. That is not a statistical measure; it is a qualitative judgment necessarily dependent on the specific circumstances of that particular workplace. The attendance records of others may need to be factored into the analysis to enable determination of how operational needs can be covered, but in a qualitative rather than a statistical assessment.

C. Automatic Termination Clauses

McGill University Health Centre[63] is a recent decision of the Supreme Court of Canada about disability discrimination at work. The case involved arbitration of a dismissal where the collective agreement had an automatic termination clause. This particular clause stipulated that an employee was liable for dismissal after a three-year absence, with the further stipulation that attempted returns to work did not interrupt the three-year period. The particular grievor, who had been employed full-time as a medical secretary, was dismissed after a three-year absence. Her initial leave was for mental health reasons. Her attempts at a graduated return through part-time work were unsuccessful, despite extensions beyond what the collective agreement had mandated for rehabilitation periods. Shortly before her last scheduled return to full-time work, the grievor was in a car accident causing extensive injuries, rendering her incapable of returning to work. At the end of the arbitration hearing into her termination, more than three and a half years after her initial leave, her doctor could not determine a prospective return to work date. The arbitrator dismissed the union's grievance, and the Quebec Superior Court dismissed the application for judicial review. The Quebec Court of Appeal overturned that decision on the basis "that the arbitrator had not assessed the reasonable accommodation issue on an individualized basis but had instead merely applied the provision of the collective agreement mechani-

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[61] See generally Donald J.M. Brown & David M. Beatty, *Canadian Labour Arbitration*, 4th ed., Vol. 1 looseleaf (Aurora: Canada Law Book, 2009) at s. 7:6122; Morton Mitchnick & Brian Etherington, *Labour Arbitration in Canada* (Toronto: Lancaster House, 2006) at 265-68.

[62] Ronald Pink & Lori-Ann Veinotte, "Attendance Management and 'Last Chance' Agreements: A Union Perspective" in Kevin Whitaker *et al.*, eds., *Labour Arbitration Yearbook 1999-2000* (Toronto: Lancaster House, 2000) 217 at 221.

[63] *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal*, 2007 SCC 4, [2007] 1 S.C.R.161 [*McGill University Health Centre*].

cally."[64] The hospital was granted leave to appeal to the Supreme Court of Canada. The essence of the respondent union's argument was that it is "contradictory to argue, on the one hand, that accommodation must be individualized and, on the other, that the duty of accommodation can be discharged by mechanically applying a general clause."[65] The essence of the Supreme Court of Canada's majority judgment is that, as long as one removes the word "mechanically" from the union's position, there need be no contradiction between individualized accommodation and an automatic termination clause. The majority judgment of Justice Deschamps makes it clear that an automatic termination clause is not immune from challenge pursuant to human rights legislation, but her assessment is a nuanced one.

The essence of Justice Deschamps' majority judgment is an explanation of why an automatic termination clause is a relevant consideration. This particular automatic termination provision, with its three-year limit, is an especially long one. On the one hand, as Justice Deschamps properly notes, lengthy termination clauses would often provide more protection than an individualized assessment based on human rights legislation: in particular circumstances, the needs of the disabled employee would frequently be satisfied well before the specified limit.[66] On the other hand, she reiterates that it is not permissible to contract out of human rights legislation, which demands an individualized assessment of the circumstances of the disabled employee. If an automatic termination provision provides a shorter period than human rights legislation would dictate in an individual case, it is legally ineffective.[67]

Still, the automatic termination clause is relevant to a determination of what human rights legislation demands. An automatic termination clause is "negotiated accommodation".[68] Especially given that the negotiation is between parties familiar with the workplace but with different interests, the clause is relevant evidence as to what the employer and union consider, in general, to be undue hardship in that employment context.[69] The clause may be inconclusive with respect to what generally constitutes undue hardship or with respect to the exceptional nature of the particular case. However, the clause is a "factor to consider".[70] Justice Deschamps goes on to say the following:

> Reasonable accommodation is thus incompatible with the mechanical application of a general standard. In this sense, the Union is correct in saying that the accommodation measure cannot be decided on by blindly applying a clause of the collective agreement. The arbitrator can review the standard provided for in the collective agreement to ensure that applying it would be consistent with the employer's duty to accommodate.[71]

Justice Deschamps concludes that the arbitrator properly decided the hospital had established undue hardship in this case. She held that he had applied the automatic termination clause, but not "mechanically". He applied it "only after having reviewed and analysed the evidence."[72]

Although she does not precisely describe it in such terms, Justice Deschamps' approach should be commended as a move toward a systemic assessment of undue hardship. Rather than an ad hoc process that treats every case as an isolated instance, it is preferable to think generally about what kind of long-term absenteeism would constitute undue hardship. Employers and unions are thus encouraged to negotiate automatic termination clauses, and to negotiate generous ones, so as not to leave themselves vulnerable to human rights challenges. Any case within the

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[64] *Ibid.* at para. 8.
[65] *Ibid.* at para. 9.
[66] *Ibid.* at para. 25.
[67] *Ibid.* at paras. 20-25.
[68] *Ibid.* at para. 18.
[69] *Ibid.* at para. 19.
[70] *Ibid.* at para. 20.
[71] *Ibid.* at para. 22.
[72] *Ibid.* at para. 30.

termination clause is automatically resolved. Any case outside the termination clause could possibly give rise to a challenge, but there will be a heavy evidentiary burden to succeed in such a challenge.[73]

Ron Pink and Lori-Ann Veinotte have argued that "[i]f a workplace does not have problems with respect to absenteeism, it is unnecessary to implement such a[n attendance] policy."[74] I disagree. Confronting the issue in an ad hoc manner, responding to particular cases in crisis-management mode, presents the risk of making mistakes. Assessing undue hardship in an anticipatory manner, outside an often-charged atmosphere of a specific case, is generally preferable. It can take the pressure off individual disabled employees who may already feel vulnerable. Approaching accommodation up to the point of undue hardship in a systemic fashion, while still accounting for individual circumstances, will be less marginalizing to individual disabled employees.

V

CONFLATING THE PRIMA FACIE CASE AND THE BFOR

Wherever there is a BFOR provision, the Supreme Court of Canada has been careful to clearly separate the analysis of the prima facie case from the BFOR. The onus is on the complainant to establish the prima facie case of discrimination, and on the respondent to establish the BFOR.[75] Even in *O'Malley* where the defence fell outside the scope of the BFOR, the analytical split between the prima facie case and the respondent's defence was maintained.[76] The analytical separation not only distinguishes the onus of proof but also ensures that issues of justification are stringently scrutinized. The unified approach from *Meiorin*, whereby the BFOR analysis applies equally to direct and adverse effects discrimination, reinforces the separation of the BFOR analysis from the prior establishment of the prima facie case of discrimination.[77] Any blurring of that distinction risks weakening the scrutiny of respondents' justification arguments.[78] Such blurring has recently occurred, both at the Supreme Court of Canada level and at the human rights tribunal level.

The previous section included a detailed discussion of the majority judgment of Justice Deschamps in *McGill University Health Centre* where she quickly assumed a prima facie breach and concentrated her analysis on the BFOR defence.[79] Thus, Justice Deschamps continued the analytical separation between the prima facie case and the BFOR. In contrast, the minority judgment of Justice Abella (with Chief Justice McLachlin and Justice Bastarache in agreement) concurring only in result, blurs this distinction. Justice Abella concluded there was not even a prima facie case of discrimination, such that the duty to accommodate never arose. She reasoned that "[t]he essence of discrimination is in the arbitrariness of its negative impact".[80] Yet, since the 1982 decision in *Etobicoke*,[81] it has been clear that issues of arbitrariness are only to be assessed in the BFOR/Q part of the analysis.

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[73] *Ibid.* at para. 38.

[74] Pink & Veinotte, *supra* note 62 at 218.

[75] *Etobicoke*, *supra* note 14 at 208.

[76] *Supra* note 30 at 558-59.

[77] *Supra* note 32 at para. 54.

[78] In *Charter* analysis, similar issues arise in the relationship between s. 1 and s. 15. For a discussion of this relationship in disability cases, see Dianne Pothier, "Reconsideration of *Eaton v. Brandt County Board of Education* by the Women's Court of Canada" (2006) 18 C.J.W.L. 121 at 142.

[79] *Supra* note 63 at para. 9. Deschamps J. notes that leave to appeal to the S.C.C. was granted on the issue of the scope of the accommodation duty.

[80] *Ibid.* at para. 48.

[81] *Supra* note 14.

While I agree with Justice Abella that parties should be encouraged to negotiate generous automatic termination clauses,[82] such agreed-upon clauses do not mean that there is no prima facie case of discrimination. The employees most likely to lose their jobs because of the automatic termination clause are those who have been off work because of a disability.[83] Not all disabled employees would be vulnerable, but those with particular kinds of disabilities would be especially vulnerable—a classic case of adverse effects discrimination. The link to the ground of disability, though not universal, is clear, and makes out the prima facie case. The rejoinder that a bare minimum requirement of being able to perform the job is to be able to show up for work goes to justification. Determining how much absence from work is incompatible with one's status as employee is clearly a BFOR issue. Some absence from work for health reasons is to be expected for most, if not all employees, without detracting from their basic qualifications for their jobs. When Justice Abella zeroes in on questions of arbitrariness and unfairness, she conflates the prima facie case and BFOR analysis. She jumps too quickly to the conclusion that arbitrariness and unfairness are absent.

> This [automatic termination clause] does not target individuals arbitrarily and unfairly because they are disabled; it balances an employer's legitimate expectation that employees will perform the work they are paid to do with the legitimate expectations of employees with disabilities that those disabilities will not cause arbitrary disadvantage. If the employee is able to return to work, the same or an analogous job remains available. If not, he or she lacks, and has lacked for three years, the ability to perform the job. This, it seems to me, is precisely what is protected by s. 20 of the *Quebec Charter* which states, in part, that "[a] distinction, exclusion or preference based on the aptitudes or qualifications required for an employment ... is deemed non-discriminatory."
>
> On the facts and the findings of the arbitrator, the claimant did not establish prima facie discrimination. Absent this, the employer is not called upon to justify the standard or its conduct.[84]

Justice Abella's reliance on section 20 contradicts her conclusion that there is no prima facie discrimination, because section 20 *is itself* the BFOR defence. By not addressing accommodation at all, Justice Abella cannot contemplate accommodation in systemic terms. Nor is there much room in this conflated analysis for challenging able-bodied norms.

If there were no express BFOR provision,[85] Justice Abella's analysis might be appropriate. If there were simply a general prohibition of discrimination on a list of prohibited grounds, it would be necessary to read in some implicit limitations such as unfairness or arbitrariness. I disagree with Chief Justice Lamer's comment in *Berg* that, in the then absence of an express BFOR provision, "it was not open to the respondent School to argue that the treatment of the complainant, although based on a prohibited ground of discrimination, was nevertheless reasonably justified."[86] If a defence could be read in for adverse effects discrimination in *O'Malley*,[87] it could also be read in for direct discrimination in *Berg*.[88] Otherwise, absurd results would follow—such as giving the right to drive to someone who is blind. Yet even in *O'Malley*, where the Court recognized an implicit defence available to respondents,[89] it analytically separated the

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[82] *McGill University Health Centre*, *supra* note 63 at paras. 62-63.

[83] *Ibid.* at para. 12

[84] *Ibid.* at paras. 63-64.

[85] There are now express BFOR provisions in human rights legislation in all Canadian jurisdictions.

[86] *University of British Columbia v. Berg*, [1993] 2 S.C.R. 353, 102 D.L.R. (4th) 665 at 363 [*Berg* cited to S.C.R.] (Berg, who had a mental disability, was a graduate student at the University of British Columbia who had been denied a rating sheet [a type of transcript] and a key to the building in which her program's offices were located. These denials followed an incident in which Berg tried to jump through a plate glass window. Her doctor subsequently advised a university official that her depression was under control, and that such behaviour was not likely to be repeated.).

[87] *Supra* note 30 at 554-55.

[88] Although I would say any justification defence should have failed in *Berg*, *supra* note 86, it should have at least been arguable.

[89] Even though the defence criteria were not satisfied by Simpsons-Sears in the particular case.

prima facie case and the respondent's implicit defence. Especially where there is an explicit BFOR provision, as there clearly is in the *McGill University Health Centre* case, it is crucial not to confuse BFOR issues with prima facie case issues.[90] To conflate the two absolves the respondent's conduct from critical scrutiny, and makes it hard to even recognize the impact of dominant norms.

There is another situation where conflation of the prima facie case and the BFOR emerges—as a result of comparator group assessment. The Supreme Court of Canada's reliance on the absence of a proper comparator as fatal to a section 15 *Charter* claim[91] has prompted questions about the necessity of comparators in human rights cases. Comparators are potentially problematic in disability cases where the disability raises issues that are specific to the particular disability, and requires accommodation that has no parallel for able-bodied employees.

In *Lane*,[92] an employee with bipolar disorder was dismissed upon manifesting symptoms soon after he started a job with ADGA. Counsel for the respondent employer argued that no prima facie case of discrimination had been made out because no comparator group had been treated differently:

> … Mr. Bird went on to argue that the appropriate comparator group in this case was other probationary employees at ADGA. If the Tribunal accepted that proposition, according to Mr. Bird, it was clear that ADGA would have dismissed any probationary employee working on a project of the kind for which ADGA had hired Mr. Lane if the company had any doubts as to that person's reliability, ability to work under pressure, and, most importantly, where there was a risk that the employee would require significant periods of leave at unpredictable times. According to Mr. Bird, the company would have dismissed any employee in that situation on the basis of inability to perform the essential functions of the position for which ADGA had hired that person, whether or not that incapacity was the result of disability or some other cause. As a consequence, Mr. Bird submitted that the Commission had failed to establish a critical element of the threshold to its case - that, in terms of section 5, ADGA had treated Mr. Lane differentially from the appropriate comparator group of all other probationary employees.[93]

Adjudicator Mullan rejected the argument that the claim about "inability to perform the essential requirements of the position" could be assessed without canvassing the duty to accommodate up to the point of undue hardship.[94] To do otherwise would "violate the structure of the legislation."[95] Mullan went on to question the requirement of comparator groups in human rights cases, reviewing recent authorities.[96] He went further to give the following analysis of comparators in the event that they were indeed necessary:

> However, in the alternative, if the correct interpretation is that it is legally necessary for the Tribunal to select a comparator, as argued by ADGA, for the purposes of determining whether Mr. Lane was treated differentially, I would identify the comparator as all probationary employees who could possibly need to take unpredictable periods of sick leave and even [short-term disability] and [long-term disability]. How ADGA would treat such employees is peculiarly within the knowledge of ADGA. Certainly, the primary onus of establishing differential treatment as a component of discrimination rests with the Commission. Nonetheless, I accept that, with respect to questions such as this, once the Commission has established that disability was a factor in the decision to dismiss, it is incumbent on

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[90] Moreover, it is alarming that the confusion is coming from Abella J., a former Chair of the Ontario Human Rights Commission and author of *Equality in Employment: The Report of the Royal Commission on Equality in Employment* (Ottawa: Supply and Services Canada, 1984). Furthermore, it is disconcerting that Abella J.'s judgment was supported by McLachlin C.J.C., the author of the leading Supreme Court of Canada BFOR decision (*Meiorin*, *supra* note 32).

[91] *Hodge v. Canada (Minister of Human Resources Development),* 2004 SCC 65, [2004] 3 S.C.R. 357; *Auton (Guardian ad litem of) v. British Columbia (Attorney General),* 2004 SCC 78, [2004] 3 S.C.R. 657.

[92] *Supra* note 17.

[93] *Ibid.* at para. 123.

[94] *Ibid.* at paras. 125-126.

[95] *Ibid.* at para. 125.

[96] *Ibid.* at paras. 127-131.

> the Respondent to lead evidence to the effect that this is the way in which it would have dealt with any probationary employee about which it had doubts on the score of reliability.[97]

Mullan ultimately rejected the employer's argument for lack of evidence regarding the treatment of other probationary employees "about which [the employer] had doubts on the score of reliability":[98]

> Indeed, it may be that, as a matter of precedent within the ADGA workplace, this is a totally theoretical question and that the dismissal of Mr. Lane was a one-off or unique occurrence in terms of the chosen comparator group. Furthermore, ADGA certainly did not produce any workplace policy to this effect. This too raises questions of the relevance of the identification of a comparator group in Code cases based on specific, individualized situations as opposed to section 15 *Charter* challenges to particular government policies.[99]

Mullan's comparator analysis improperly conflated the prima facie case and the BFOR analysis, and improperly reverted to a formal equality analysis. Mullan's analysis would mean that an employer would escape a discrimination finding as long as it could adduce evidence that it would fire all those whose attendance was unreliable, even if all such instances were disability cases. Moreover such analysis excludes any assessment of the ability to manage attendance issues. This approach contradicts Mullan's earlier analysis.

Identifying comparator groups for human rights disability cases is only a problem if one looks for formal inequality alone, and ignores adverse effects discrimination. By framing the comparison amongst those raising reliability of attendance issues, Mullan is assuming there could be no redress if all such persons were fired. That would amount to identical treatment—formal equality—of all, without accounting for the difference attributable to disability. The disability question is whether, with proper accommodation, the concerns about reliability of attendance can be adequately addressed without undue hardship. In order to get to that question, the analysis needs to reach the BFOR stage of analysis. So how does one frame the comparison at the prima facie case stage in order to get to the BFOR analysis?

At the prima facie stage, the pertinent fact is that Lane was fired under circumstances linked to his disability, whereas other probationary employees were not fired. This entails a comparison between the disabled and the non-disabled (able-bodied). The argument that there is good reason to fire Lane because his disability results in an inability to perform the essential requirements of the position is a BFOR defence—a defence necessitating consideration of the duty to accommodate up to the point of undue hardship.

Mullan notes that in *Meiorin* there is no discussion of the appropriate comparator group.[100] While that is technically accurate, I would not, as Mullan does, take that as questioning the requirement of comparators. Rather, I would take that as an indication that the comparator group in *Meiorin* was so obvious as to not require comment. The challenged aerobic fitness test in *Meiorin* was disproportionately passed by men and failed by women, owing to physiological differences between the sexes. The relevant comparator group was women being compared to men. That comparison holds notwithstanding the fact that some men failed the test and some women passed it. To suggest otherwise would be to preclude disproportionate impact qualifying as adverse effects discrimination, gutting the concept. *Meiorin* clearly affirms disproportionate impact as adverse effects discrimination,[101] and affirms that any claimed justification for relying on

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[97] *Ibid.* at para. 132.

[98] *Ibid.* at para. 133.

[99] *Ibid.*

[100] *Ibid.* at para. 127.

[101] *Meiorin*, *supra* note 32 at paras. 39-42.

the disproportionate impact is a BFOR issue.[102] To be able to challenge systemic discrimination and dominant norms, a clear focus on any justification claim is essential.

Thus, in *Lane*, it does not benefit ADGA at the prima facie case stage to say that all probationary employees who raised attendance reliability concerns were or would be fired any more than it avails the British Columbia government in *Meiorin* to say that all who failed the aerobic fitness test were terminated. Similarly, there was no advantage at the prima facie case stage in *O'Malley* for Simpsons-Sears to say that all employees who were unavailable to work on Saturdays were disentitled to full-time status.

Although they are both instances of adverse effects discrimination, there is a difference between *O'Malley* as a categorical exclusion case (all observant Seventh Day Adventists were unable to work on Saturdays) and *Meiorin* as a disproportionate impact case (although women disproportionately failed the test compared to men, some women passed the test). In the disproportionate impact cases, it cannot be that the comparison is with those who face the same consequences as the claimant(s)—in *Meiorin* men who failed the aerobic fitness test—because that would preclude ever finding discrimination in disproportionate impact cases.

In a recent case, the Nova Scotia Court of Appeal fell into this error, though outside the employment context, and dealing with the *Charter* rather than human rights legislation. *Boulter v. Nova Scotia Power Inc.*[103] involved a challenge to a statutory provision requiring all the residential customers to have the same power rates.[104] The challenge claimed discrimination against those under the poverty line in not taking account of their inability to pay. The claim was framed as either direct discrimination against the poor, or discrimination against those identified by enumerated grounds, constituting groups that were disproportionately poor. The Nova Scotia Court of Appeal rejected poverty as an analogous ground of discrimination.[105] It also rejected claims of adverse effects discrimination based on, *inter alia*, disability.[106] The latter claims were founded on evidence that the disabled are disproportionately poor compared to the non-disabled. Justice Fichaud, speaking for a unanimous Court of Appeal, said there was no discrimination based on, *inter alia,* disability, because for those below the poverty line, whether disabled or non-disabled, the inability to pay was never taken into account.[107] On this analysis, only in adverse effects cases of categorical exclusion (where *only* the claimants faced the consequences) could a comparator be identified so as to successfully claim discrimination. In *O'Malley*, all those, and only those, with a Saturday Sabbath that precluded work faced loss of full-time employment; they were compared with those without a Saturday Sabbath precluding

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[102] *Ibid.* at paras. 75-82.

[103] (2009), 275 N.S.R. (2d) 214 (C.A.), leave to appeal to the S.C.C. refused, [2009] S.C.C.A. No. 172.

[104] S. 67(1) of the *Public Utilities Act*, R.S.N.S. 1989, c. 380 provides as follows:

> All tolls, rates and charges shall always, under substantially similar circumstances and conditions in respect of service of the same description, be charged equally to all persons and at the same rate, and the Board may by regulation declare what shall constitute substantially similar circumstances and conditions.

In an earlier case, as a matter of statutory interpretation, the Nova Scotia Court of Appeal had ruled:

> Section 67(1) is not ambiguous: "rates … shall always … be charged equally to all persons and at the same rate" in substantially similar "circumstances and conditions in respect of service of the same description." The Board cannot reduce the rate to a low income customer who receives the same service as a high income customer.

Dalhousie Legal Aid Service v. Nova Scotia Power Inc., 2006 NSCA 74, 245 N.S.R. (2d) 206 at para. 39. The *Boulter* case challenged the statute, so interpreted, as a violation of s. 15 of the *Charter*.

[105] *Supra* note 103 at para. 43.

[106] *Ibid.* at paras. 71-81.

[107] *Ibid.* at para. 67. Because of this conclusion, Fichaud J.A. did not discuss the degree of disproportionate impact needed to establish a prima facie case of discrimination.

work on Saturdays.[108] In a categorical exclusion case, all of those not in the claimants' category do not face the consequences the claimants are challenging. However, in a disproportionate impact case, there are, by definition, some outside the claimants' category who face the same consequences as the claimants. If, in *Boulter*, there is no discrimination because both disabled and non-disabled persons face inability to pay because of poverty, then *Meiorin* was wrongly decided; both men and women who failed the aerobic fitness test were subject to termination of employment, meaning no discrimination. To recognize that *Meiorin* was correctly decided means the comparison must be made instead between those fired for failing the test (disproportionately women) and those who kept their job upon passing the test (disproportionately men).

In assessing disability claims in employment, the comparison must similarly be made between the disabled individuals who face adverse job consequences and the non-disabled individuals who do not face job consequences. In such a framework, the unique needs and/or limitations of particular disabilities do not yet factor into the analysis. In the employment context, these unique circumstances attributable to disability enter the analysis as part of the BFOR justification, subsequent to the establishment of the prima facie case of discrimination, made on the basis of a proper comparison with the able-bodied. Such a split between the prima facie case and the BFOR stages of the analysis is critical to identifying, and challenging able-bodied norms.

Thus, the fact that bipolar disorder raises unique issues about monitoring employees[109] does not deny the relevant comparison in *Lane* between the disabled and the non-disabled. As Justice McLachlin (as she then was) said in *Canadian Egg Marketing Agency v. Richardson*:

> As in any discrimination analysis, the key is determining who the appropriate comparators are—who are the "others" with whom the individual is entitled to be equal, in relation to whom the individual is entitled not to be disadvantaged? Artificial differences which place the individual in a class of her own must be avoided: *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143. The reality or "substance" of the individual's situation, as compared with others in relation to the purpose and goal of the anti-discrimination provision, must be seized.[110]

Similarly, the fact that pregnancy is unique to one sex does not detract from the claim that pregnancy discrimination amounts to sex discrimination[111] even though one cannot claim that pregnant men were treated differently from pregnant women. In relation to sex and disability, respectively, the comparison is not across the effects of pregnancy or the effects of bipolar disorder, but concerns the job-related consequences resulting from the pregnancy or bipolar disorder. If job consequences flow from a prohibited ground of discrimination, the comparator group is comprised of those individuals with different characteristics within that prohibited ground who do not face those job consequences.

Thus the comparator analysis must focus on the existence of job consequences, not their underlying rationale. Any argument justifying the job consequences is a BFOR issue. Mullan's comparator analysis improperly conflates the existence and justification of the job consequences.

Although Justice Abella in *McGill University Health Centre* and Adjudicator Mullan in *Lane* came to what I would consider the proper conclusions, their analytical method is worrisome. Historically, the analytical separation between the prima facie case and the BFOR has enabled the BFOR to be a stringent test. I have argued above that the *Meiorin* approach to the BFOR needs further development to increase its systemic impact. Conflating the prima facie case and the BFOR is counterproductive in that respect.

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[108] *Supra* note 30 at 555-56.

[109] The main accommodation sought by Lane was that he be monitored for early signs of the onset of a manic episode to enable intervention to ward off the onset of a full-blown manic episode (*supra* note 17 at paras. 2-3).

[110] [1998] 3 S.C.R. 157 at para. 125, 166 D.L.R. (4th) 1.

[111] *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219, 59 D.L.R. (4th) 321.

CONCLUSION

Equality for disabled workers requires workplaces that are responsive to their diverse needs. The social model of disability places the emphasis on fixing the environment, not on fixing the disabled worker. That has implications for the meaning of disability, the meaning of discrimination, and the responsibilities of employers in compliance with non-discrimination obligations.

The Supreme Court of Canada has interpreted disability purposefully in recognition of the importance of challenging barriers to inclusion. The incorporation of adverse effects discrimination into prohibited discrimination enables identifying and challenging non-disabled norms. A stringent BFOR test, including a respondent's duty to accommodate up to the point of undue hardship, places a significant legal onus on a respondent to justify its claim that a particular disability precludes performance of the position's essential requirements.

Still, the prevailing approach to issues of disability discrimination has been carried out in an ad hoc fashion. Ad hoc responses have a limited capacity to challenge dominant able-bodied norms and, therefore, a limited capacity to truly integrate disabled workers. In contrast, a systemic approach contemplates diverse norms from the outset. The importance of individualizing the response to disability is not inconsistent with a systemic approach, because a systemic approach facilitates any required tailoring. Building in flexibility at the outset typically makes adjustments easier compared to an ad hoc attempt to counteract initial rigidity.

Canadian law has yet to clearly embrace a systemic approach to disability discrimination. There are some hopeful signs, especially in assessments of the duty to accommodate. But there are also some worrying signs, for example in instances where the distinction between the prima facie case and the BFOR is blurred. Such blurring inhibits consideration of differential needs owing to disability.

Canadian human rights law has gone through considerable evolution over the last few decades. Minority judgments have become majority holdings in fairly short order. Disabled workers have made significant gains, but these are far short of a fundamental transformation of the workplace. The future potential for fundamental transformation will largely depend on the extent to which systemic approaches to disability discrimination can be incorporated into anti-discrimination law.

COULD PARENTS BE HELD LIABLE FOR NOT IMMUNIZING THEIR CHILDREN?

Rebecca Rodal & Kumanan Wilson[*]

Although most vaccines are highly effective, vaccination does not confer 100% immunity to all those immunized, and some individuals are unable to receive vaccinations. But the phenomenon of herd immunity, which arises when a large enough percentage of the population is vaccinated, more completely prevents the development of disease outbreaks by disrupting the possibility of person-to-person transmission of a pathogen. In the presence of an outbreak of a vaccine preventable disease, such as measles, a percentage of those who develop the illness may well have received the vaccine, since effectiveness of the vaccines in individuals varies. The implication of these basic scientific facts is that the decision by some parents to not vaccinate their children amplifies the possibility for an otherwise preventable outbreak to occur, and places even children who are vaccinated at risk. This issue has gained some currency at a time when vaccination concerns are rising.

In our analysis, using measles as an example, we examine the question of whether parents whose immunized children have contracted a disease due to breakdown in herd immunity may have recourse in tort against those parents who have refused to immunize their children. There are a few barriers to success which such parents may face. At the outset, identifying a specific individual as responsible would be virtually impossible. However, the potential to hold liable a group of parents who chose not to vaccinate their children does exist. In a disease like measles, with a low threshold for loss of herd immunity, it is possible to identify a small number of individuals, often in a geographical or social cluster, whose collective decision not to immunize has led to an outbreak. As a result, it can be said that each member of this group materially contributed to the emergence of an outbreak, which would not likely have occurred otherwise. However, while this may potentially be an answer to the causation problem, a main limitation to such an approach is the question of foreseeability, that parents may not know when making decisions on vaccination that they could be putting other children, including vaccinated children, at risk. The other major limitation is that under the status quo, exemptions to school-based immunization programs are authorized by statute and are presented as choices which relate only to individual, rather than to community health.

Under such a regime it is unlikely that a parent of an injured child could succeed in tort, when the supposedly negligent actions have been either explicitly or implicitly approved by the public health authorities. We hypothesize that an altered regime of disclosure and risk assumption in childhood immunization exemptions could have the effect of removing the statutory authority defence and of making parents aware of the possible negative consequences to other children. This would require clear transmission of information to parents that the decision to vaccinate a child is not only for the benefit of the individual child, but also the benefit of other children with whom the child may come into contact.

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INTRODUCTION

In 1989, Quebec City experienced an outbreak of measles. At first glance, the outbreak appeared unusual because the majority of cases occurred in vaccinated individuals. However, a closer examination of the data reveals that it was not a failure of the vaccine which led to the outbreak of measles in a highly vaccinated population. Rather, an epidemiological study following school children who developed measles and their siblings reinforces the strong protective effects of vaccination and the real risks associated with non-vaccination.[1] Fifty-eight of the 462 (13%) monitored siblings contracted the highly infectious disease. Of the monitored siblings, 17 were unvaccinated, and all of them (100%) contracted measles. In contrast, only 41 of the 445 (8%) vaccinated siblings also developed the disease—a small percentage always subsists given that vaccination is not 100 percent effective.[2]

These results not only reinforce the known protective effects of vaccination, but also illustrate that the dangers of refusing vaccination are not simply limited to those who abstain. The results point to the loss of herd immunity, which is established when a large proportion of immunized individuals within a population makes the chain of disease transmission difficult to maintain. The decision by some parents to *not* vaccinate their children permitted the spread of an epidemic that would have otherwise abated in the presence of higher rates of immunization.

Importantly, the results also illustrate the fact that even vaccinated children need protection against infectious diseases, since vaccines do not have perfect efficacy. Moreover, some children cannot be immunized at all, due to medical risks such as allergy to vaccine components. These children must rely on the protection given by herd immunity, which in turn depends on substantial compliance with recommended immunization schedules in the population to prevent the spread of communicable diseases.

These findings, and the central role herd immunity plays in the success of immunization programs, pose important ethical and legal questions concerning the obligations of parents to vaccinate their children not only for their children's benefit, but for the benefit of others. It seems unfair that a parent who follows the public health recommendations suffers due to the choices of other parents who have not followed these same recommendations. At the same time, the right of parents to make decisions on behalf of their children is integral to their role as guardians and supervisors. It is unclear, though, that the authority of parents as surrogate decision-makers for their children should trump the community's need to be protected from the spread of preventable disease.

Here, we examine the question of whether parents who took steps to reduce the risk of their child contracting a communicable disease and passing it on within the community may have recourse in tort against those parents who refused to take similar steps. What is an individual's potential liability for failing to immunize his or her child, when this failure leads to the infection of others? The Canadian legal system is meant to represent the societal norms reflective of values held to be important to Canadians. When attempting to balance collective security with individual choice regarding routine immunization, the answers are not obvious. These interests often conflict in the field of law and health, and the courts seek ways to achieve

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[1] G. De Serres *et al.*, "Measles Vaccine Efficacy During an Outbreak in a Highly Vaccinated Population: Incremental Increase in Protection with Age at Vaccination up to 18 Months" (1995) 115:2 Epidemiology & Infection 315.

[2] Public Health Agency of Canada, *Canadian Immunization Guide,* 7th ed. (Ottawa: Public Works and Government Services Canada, 2006), online: PHAC <http://www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php> [*Immunization Guide*].

a balance between protecting the health of others and preserving the autonomy of individual actors.[3]

Finding the correct balance in this scenario poses challenges to the status quo definition of the standard of care in the area of immunization, as well as to the traditional approach to causation, given the unique phenomenon of herd immunity. Because the government has explicitly allowed non-medical conscience-based exemptions from school immunization requirements, a statutory defence may, at present, create an insurmountable barrier to a plaintiff. However, there is an argument that this current model does not adequately encourage maintenance of herd immunity at a time when exemptions are on the rise, and can therefore place the greater population at risk.[4] We hypothesize that an altered regime of disclosure and risk assumption in childhood immunization exemptions could have the effect of removing the statutory authority defence. Whether or not a plaintiff will be barred by a statutory authority defence depends on the way in which exemptions from school immunizations are framed: as an equally acceptable option to immunization, or as a risky choice for which one ought to be liable should things go wrong.

To focus our argument we will specifically examine this issue as it pertains to vaccinated children who develop measles, the scenario which began this article. While some of our arguments are transferrable to other vaccines, ultimately each of these analyses will have to be conducted individually in order to take into consideration such factors as the reproductive number of the disease, the morbidity resulting from the disease, and the safety and effectiveness of the vaccine. To begin our analysis, we will first look at why this question is becoming increasingly relevant. Here, we discuss some of the scientific properties of vaccines and measles transmission. We will then examine whether parents who fail to vaccinate their children meet the legal tests for negligence liability. We conclude by suggesting scenarios under which liability might or might not exist.

Civil liability could prove to be a helpful factor in changing the tides of vaccine acceptance. It could provide some recourse to parents who have complied with public health recommendations but who are harmed by the choices of others, and could aid in changing social attitudes, which will help in avoiding large scale outbreaks of measles and other preventable diseases. Due to the availability of a statutory defence for conscientious objectors, as well as a lack of clarity in the current standard of care across the country, it appears unlikely that a parent or their affected child could currently succeed in a lawsuit. We would argue that government and public health authorities should move to clearly state that the immunization of school-aged children is a public health and safety requirement benefiting the greater community. Exemptions should remain a personal choice, but they should be reframed as one that does not negate liability if it results in a foreseeable and identifiable harm.

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[3] As an example, the Supreme Court of Canada in *Dobson (Litigation Guardian of) v. Dobson,* [1999] 2 S.C.R. 753, 174 D.L.R. (4th) [*Dobson*] examined the important balance between a pregnant woman's rights of individual autonomy and the fetus' right to be protected from prenatal harm caused by the mother's actions.

[4] See Saad B. Omer *et al.*, "Vaccine Refusal, Mandatory Immunization, and the Risks of Vaccine-Preventable Diseases" (2009) 360:19 New Eng. J. Med. 1981 [Omer *et al.*, "Vaccine Refusal"].

I
FRAMING THE QUESTION

Universal vaccination programs are central components of public health programs around the world, and have been heralded as one of the greatest public health achievements of the 20th century. In Canada, all provinces have instituted childhood vaccination programs for measles, mumps, and rubella ("the MMR vaccine"), haemophilus influenza B, diphtheria, pertussis, tetanus, and polio.[5] Furthermore, in the last fifty years, immunization has saved more lives in Canada than any other health intervention.[6] Yet, despite the long-standing, documented successes of these vaccinations in alleviating and even eradicating the spread of infectious diseases, there is increasing parental anxiety surrounding the decision to vaccinate children. The most apparent reason for this trend is concern about the risk of adverse effects from immunization, including the purported but unsubstantiated association between vaccination and autism, and fears about the negative health effects of vaccine preservatives such as thimerosol. These concerns, bolstered by media reports and Internet-based communication, are gaining momentum.[7] In addition, people may question the need to continue vaccination programs, as the success of these programs has reduced the incidence of vaccine-preventable diseases to the point where the general public no longer sees these diseases as a real threat. The perception that communicable diseases do not pose a substantial risk creates a context in which the potential for side effects associated with vaccines may appear more threatening than the diseases themselves.[8] However, these perceptions may actually lead to the resurgence of these diseases due to insufficient rates of immunization and a corresponding loss of herd immunity.

The anti-vaccination movement has recently come into the mainstream. In the United Kingdom, concerns about the association between the MMR vaccine and the development of autism spectrum disorders contributed to a decline in vaccination rates and a subsequent increase in measles outbreaks.[9] Since then, measles has once again been declared endemic in the U.K., fourteen years after local transmission of measles had initially been halted.[10] In the United States, prominent celebrities and political figures have argued in public that thimerosol preservatives in vaccines may be associated with the apparent increasing rates of autism spectrum disorders in the country.[11] Recently, a settlement in the U.S. no-fault compensation courts resulted in the U.S. Centers for Disease Control and Prevention ("CDC") compensating a child with a rare mitochondrial disorder who developed an autism spectrum disorder following vaccination.[12] While the CDC and vaccine proponents argued strongly that this was not an acknowledgement of the

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[5] New vaccines supported by the National Immunization Strategy are continually introduced, including a pneumococcal vaccine, a vaccine for chicken pox and most recently, and perhaps most controversially, a vaccine for the human papilloma virus.

[6] *Immunization Guide*, *supra* note 2 at 17.

[7] Lucy Serpell & John Green, "Parental Decision-Making in Childhood Vaccination" (2006) 24:19 Vaccine 4041. Other motivating factors include concerns that vaccinations are painful, the belief that natural exposure is superior to immunization, access to resources, and a phenomenon of general distrust of the medical community or belief in conspiracy.

[8] Robert T. Chen *et al.*, "Challenges and Controversies in Immunization Safety" (2001) 15:1 Infectious Disease Clinics of North America 21.

[9] See David C. Burgess, Margaret A. Burgess & Julie Leask, "The MMR Vaccination and Autism Controversy in United Kingdom 1998-2005: Inevitable Community Outrage or a Failure of Risk communication?" (2006) 24:18 Vaccine 3921.

[10] European Centre for Disease Prevention and Control (Stockholm), "Measles Once Again Endemic in the United Kingdom" (2008) 13:27 Eurosurveillance.

[11] For more on this topic see Arthur Allen, *Vaccine: The Controversial Story of Medicine's Greatest Lifesaver* (New York: W.W. Norton & Company Inc., 2007) at chapter 10.

[12] See Paul A. Offit, "Vaccines and Autism Revisited: The Hannah Poling Case" (2008) 358:20 New Eng. J. Med. 2089 at 2089.

risks associated with vaccines, but rather the structural inadequacies in current judicial adjudication practices, the optics of the settlement lend support to those who have been arguing in favour of the link between vaccines and autism.[13]

Throughout the ongoing controversies, epidemiological evidence has not supported the association between vaccines and autism. Reviews and statements by leading institutions, such as the U.S. Institute of Medicine and the World Health Organization, have rejected the possibility that a causal link exists.[14] Rather, the increased numbers of autism cases have been attributed to various other factors, including changes in diagnostic criteria and a heightened awareness of the condition amongst parents and doctors.[15] Nevertheless, parental anxieties persist and there is evidence that these anxieties are translating into declining vaccination rates.[16]

In those Canadian provinces with school immunization policies,[17] current legislation permits parents to exempt their school-aged children from being vaccinated. These exemptions can be based on medical reasons such as previously having had the disease, or contraindication, for example an allergy to a component of a vaccine. There is also an allowance for religious or philosophical objections, which requires a witnessed statement such as a "Statement of Conscious or Religious Belief" exemption form.[18] The difficulty for public health policy-makers lies in the inclusion of philosophical exemptions, which essentially permits the opting out of conscientious objectors. Legislation allowing philosophical exemptions has been shown to dramatically increase the number of parents claiming non-medical exemptions, which could in turn increase the probability of outbreaks of vaccine-preventable diseases, especially if those claiming exemptions are clustered geographically.[19] Geographic aggregation of persons refusing vaccination through non-medical exemptions has a clustering effect which has been found to correlate with local risk of outbreaks of vaccine-preventable diseases such as pertussis.[20] These clusters may be found amongst certain demographic and socioeconomic groups, and there may be wide local discrepancies even between neighbouring counties in a single region.[21] It is important then to understand what effect the choice of some individuals not to immunize their children may have on vaccinated and unvaccinated individuals as well as the community-at-large.

The debate surrounding immunization can be characterized as a conflict between the values of public welfare and individual liberty, engaging issues of law, medicine, ethics, and policy. Public health authorities and governments present immunization as a necessary public good, as success is reliant on near-universal compliance. The practice of routine immunization encourages healthy individuals to assume some level of individual risk to benefit their long-term per-

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[13] Of note, subsequently the U.S. court of Federal Claims rejected compensation for three test cases arguing that autistic spectrum disorder was associated with vaccination.

[14] See Michelle Meadows, "IOM Report: No Link Between Vaccines and Autism" (2004) 38:5 FDA Consumer 18 at 19; World Health Organization—Global Advisory Committee on Vaccine Safety, "MMR and Autism", online: WHO <http://www.who.int/vaccine_safety/topics/mmr/mmr_autism/en/index.html>.

[15] See Lorna Wing & David Potter, "The Epidemiology of Autistic Spectrum Disorders: Is the Prevalence Rising?" (2002) 8:3 Mental Retardation & Developmental Disabilities Research Reviews 151.

[16] See Serpell & Green *supra* note 7.

[17] At present, this includes Ontario and New Brunswick *infra* notes 64 and 65. Other provinces follow the recommended immunization schedule but do not have separate legislation mandating compliance.

[18] For a summary of the Ontario Scheme, see City of Ottawa, "Immunization Requirements for School Registration", online: City of Ottawa <http://www.ottawa.ca/residents/health/conditions/id_prevention/immunization/requirements_en.html>.

[19] Joseph W. Thompson *et al.*, "Impact of Addition of Philosophical Exemptions on Childhood Immunization Rates" (2007) 32:3 American Journal of Preventative Medicine 194.

[20] Saad B. Omer *et al.*, "Geographic Clustering of Nonmedical Exemptions to School Immunization Requirements and Associations with Geographic Clustering of Pertussis" (2008) 168:12 American Journal of Epidemiology 1389.

[21] Omer *et al.*, "Vaccine Refusal", *supra* note 4 at 1983.

sonal health as well as the overall health of the whole community. Nevertheless, the responsibility of the individual to contribute to public health has been downplayed compared to the notion of vaccination as a medical treatment subject to personal approval, leaving these ideas in tension. Decision-making about whether to pursue routine or particular immunization for oneself or one's child is an individual choice, requiring informed consent. But conversely, the public good and prevention of disease depends on a large majority of the population making the "right" choice. In fact, it is not simply a public good versus an individual good, but a public good versus a public harm. That is, each non-medically based choice to avoid vaccination contributes to the risk of public harm. If this movement reaches a tipping point where herd immunity is broken, it could inspire a backlash by parents of children who have been negatively affected by these decisions. Since recent developments have shown a concerning trend in this direction, a discussion of possible legal consequences is timely. First, though, it is useful to briefly discuss some of the scientific aspects of vaccination and measles infection.

A. The Science of Vaccination and Epidemiology of Measles

When an individual is infected by a pathogen, the body launches an immune response to control and destroy the foreign invader. The development of this response can take time. It requires the body's ability to recognize the specific components of the pathogen, called antigens. The body then manufactures specific antibodies which target these antigens. In addition, the body also creates a memory of the antigen to which it was exposed, so that on subsequent exposures it can respond immediately. A vaccine attempts to replicate this process by stimulating the body to create a memory of an antigen, facilitating rapid response to it on future exposure. The goal of vaccination is to present antigens to the human body in a safe and controlled manner. This can be done, for example, by exposing the body to a killed virus, or to a live virus that has had its pathogenic qualities removed (known as a live attenuated virus). The effectiveness of a vaccine will depend on its ability to induce a sufficient immune response in an individual; most vaccines are not 100% effective, and often have effectiveness rates ranging from 80% to 90%.[22] Despite the imperfect coverage, the introduction of vaccine programs has been accompanied by the virtual eradication of vaccine preventable diseases in many instances, most notably smallpox.[23] This is due to a combination of factors which include the important concept of herd immunity.

When a virus enters into a human population, its ability to spread is dependent on its basic reproduction number, R_0, which reflects the number of subsequent individuals infected for each initial infection. For a virus with an R_0 of 2, every infected individual will cause the further infection of two additional individuals. As long as the R_0 is greater than 1, the infection will continue to grow and spread. If the R_0 dips below 1, the size of the epidemic will decline. In most instances, viruses will create natural immunity in enough members of a population that the R_0 will eventually decrease to below 1, and the epidemic will dissipate. Public vaccination programs simulate the creation of natural immunity in large segments of the population, and can thereby reduce the R_0 to less than 1 at the point of entry of a virus into a specific human population. For example, for a virus with a natural R_0 of 2, if the vaccine creates effective immunity in half of the population, then for every two people who would have been infected, only one will be susceptible (Figure 1). Because of this, the epidemic would no longer be able to increase in size.

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[22] See *Immunization Guide, supra* note 2.

[23] See Sandra W. Roush, Trudy V. Murphy & the Vaccine-Preventable Disease Table Working Group, "Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States" (2007) 298:18 Journal of the American Medical Association 2155, and the Centers for Disease Control and Prevention MMWR, "Progress Toward Interruption of Wild Poliovirus Transmission" (2007) 56:27 Morbidity and Mortality Weekly Report 682 at 682.

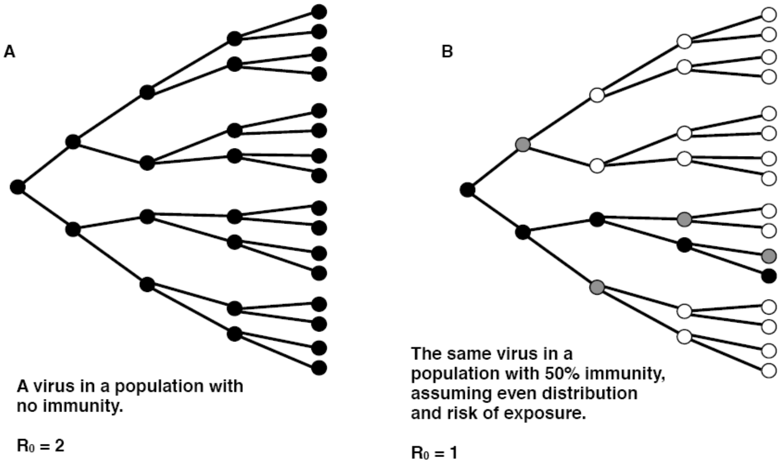

Figure 1: Our own figure representing an idealized example of how immunization impedes the spread of infectious disease. Black circles indicates an individual who has contracted the disease, grey a vaccinated individual who did not contract the disease from an infected individual, and white a disease-free individual. A) In a population with no immunity, with an R_0 of 2, an infectious disease spreads to two additional individuals for each infected individual. B) Assuming heterogeneous dispersal of the vaccine to 50% of the population, resulting in even distribution of immunity and even risk of exposure, the chain of transmission is restrained early on. Now for every two people infected, only one will be susceptible, an R_0 of 1.

Measles, a vaccine-preventable illness, causes death and severe disease in children worldwide.[24] It is particularly harmful in impoverished areas, where there is overcrowding and poor nutrition. However, even in developed countries with healthy populations, the virus can have serious effects. The measles virus is one of the most highly contagious viruses that exist today. Estimates of its natural R_0 have been placed between 15 and 25, a remarkably high number.[25] The clinical presentation of measles is the development of signs of an upper respiratory tract infection, followed by more severe symptoms; eventually the individual will develop high fevers and a characteristic rash.[26] The infectious period, however, develops prior to the pathognomonic signs of measles. This pattern of disease progression may leave individuals unaware of the need to avoid contact with others. In most instances, the individual will have spread the infection before even becoming aware that he is suffering from the condition. In general, measles is a self-limited condition characterized by the individual suffering high fevers, rash and malaise for a limited duration. In some instances the infection can also cause otitis media (an infection of the middle ear). But in rare cases, serious complications can arise. Approximately 1 out of 1000 people suffering from measles is at risk of developing encephalitis, an inflammation of the brain which can cause severe neurological problems and death. A similar proportion of people are at risk of developing a severe form of pneumonia, which accounts for most measles-associated deaths. Thus, the effects of large scale vaccine program failure could result in grave consequences to certain individuals. The measles vaccine is a live attenuated virus vaccine, with an efficacy of approximately 90%, and the epidemiological data makes clear that the introduction of universal vaccine programs for measles has dramatically reduced the prevalence of the condition.[27] It is important to remember, though, that the measles vaccine efficacy exists to a large

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[24] Robert T. Perry & Neal A. Halsey, "The Clinical Significance of Measles: A Review" (2004) 189:S1 Journal of Infectious Diseases S4 at S4.

[25] Jacco Wallinga, Janneke C.M. Heijne & Mirjam Kretzschmar, "A Measles Epidemic Threshold in a Highly Vaccinated Population" (2005) 2:22 PLoS Medicine 1152.

[26] See Perry & Halsey, *supra* note 24.

[27] See *Immunization Guide*, *supra* note 2 at 230.

extent because of the effects of herd immunity. If herd immunity is compromised due to a large unvaccinated fraction of the population, the disease may be resurrected.

II

EXAMINING POTENTIAL PARENTAL LIABILITY IN NEGLIGENCE FOR FAILURE TO IMMUNIZE

The question of whether parents could be held liable in negligence for failing to immunize their children is a complex one raising novel issues of law. Parents are proxy-decision makers for their children. In health matters it is routine to accept parental decisions as acceptable choices for their children. This is generally the acknowledged societal role of a parent and in most cases does not have a large effect on the wider community. There are limits, however, to what is acceptable when the decision may actually harm the child: there may be a legitimate interest of the state in protecting the child where parental conduct falls below an acceptable standard. This was discussed in the case of *B. (R) v. Children's Aid Society of Metropolitan Toronto*, where the Supreme Court of Canada found that Jehovah's Witness parents could not deny a blood transfusion to their child if it was needed to keep the child alive.[28] However, this case was about a medical situation of some urgency. There would be a weaker case for violating a parent's decision where the harm was much further into the future and the risk more diffuse. The added complexity of the vaccination question also lies in requiring a person to assume a personal risk for the collective good, rather than simply a personal good. Thus the societal interest in maintaining public health could potentially justify overriding parental objections in some cases, but this may be perceived as a more coercive and heavy-handed approach. For this reason, we instead examine the possible consequences in private law, more specifically in tort law.

One of the basic principles of tort law is *restitutio in integrum*, returning a person who has been injured through the fault of another to the position they would have occupied had the harm not occurred. The outcome of a case should make the plaintiff whole and attribute fault to the defendant, while allocating the loss between them in a just manner. In proving a negligence action, the burden is on the plaintiff to establish five elements, ordered here by seriousness of the challenge that they present to establishing liability for failure to immunize: (A) that the injury was not too causally distant from the tortious act, (B) that the injury was caused by the negligent action, (C) that the defendant breached an accepted standard of care, (D) that a duty of care was owed to the plaintiff in particular, and (E) that the damages are recoverable. While the reasonable person is expected to be aware of common knowledge, such as the knowledge that vaccination reduces the spread of infectious diseases, the contentious issue is whether refusal of immunization could be considered negligent. The outcome of the legal argument may rest on the quality and content of information disseminated to the public about the risks of vaccinating and the risks of not vaccinating, which determines foreseeability of harm. It also depends on the balance between individual choice and public harm, and how far this boundary can be stretched.

A. Remoteness

The first question we will examine is whether the decision that led to the adverse event is sufficiently connected with the outcome to be considered compensable. Recovery is confined to those injuries that were reasonably foreseeable as a result of negligence.[29] Thus, if a defendant were to be held negligent in the case of exposing others to a substantial risk of infectious disease, the injury would need to be fairly direct.[30] The distinction revolves around the likely knowledge

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[28] [1995] 1 S.C.R. 315, 122 D.L.R. (4th) 1 [*Children's Aid Society*].

[29] *Overseas Tankship (U.K.) Ltd. v. Morts Dock and Engineering Co. Ltd. (The Wagon Mound No. 1)*, [1961] 1 All E.R. 404, A.C. 388.

[30] Bizarre results that are beyond the realm of what would be expected are not recoverable (*Mustapha v. Culligan*, 2008 S.C.C. 27, [2008] 2 S.C.R. 114). For example, a vaccine-allergic unimmunized child in an after-school program with the infected child might be able to recover. But if the child's supervisor panics at the situa-

the non-immunizing parent would have had about the consequences of his actions. If the resulting harm is reasonably foreseeable the defendant would be liable to the extent of that damage. Therefore, if a child suffers a rare but known complication of an infectious disease, one could not argue that the child was abnormally susceptible.[31]

The question of remoteness in this instance revolves around whether the decision by a parent not to immunize his child can be considered sufficiently related to the development of a vaccine preventable condition, either by a child who is immunized or one who could not be immunized. The chain of events leading to this result would likely follow a particular pattern: a parent chooses not to immunize his child, who then becomes infected with measles; while infectious, but still clinically asymptomatic or unaware that they have measles, the child attends school; the child comes into contact with potentially susceptible children and transmits the infection to them. An argument could be made that the decision to not vaccinate, which then is followed by the transmission of an illness, is sufficiently foreseeable. This is based on our understanding of the effects of immunization, since not vaccinating greatly increases the risk of the child contracting the disease, and therefore of passing it on to others.

There are many possible intervening factors which might confuse the analysis and make the end result too remote, for example, other unvaccinated children as potential sources of the infection, an absence of adequate hygiene practices, or neglecting to take proper care to mitigate the spread of disease in the face of a measles outbreak. These factors can make it difficult to draw the line between what was foreseeable, and what was not. While the number of children who are unvaccinated or practice good hygiene may be variable, it is plausible that the science of herd immunity presents a predictable and foreseeable result, even in the presence of other mitigating or exacerbating factors. It is in fact the presence of a critical mass of unvaccinated children that leads to an outbreak, and thus it is best considered an integral part of the analysis rather than an intervening factor. Simply put, measles outbreaks do not occur when there is 100% vaccination coverage. The extent of foreseeability requires a more detailed examination of causation, and the epidemiology of vaccine-preventable diseases.

B. Causation

To establish liability, plaintiffs must demonstrate a causal link between the negligent act and the subsequent injury, which presents some difficulties in this situation. It is not enough to merely expose one to an unreasonable risk. That risk must be realized and must result in harm. In the case of failing to immunize a child, the question would be whether the failure to immunize is the direct cause of another child contracting the communicable disease. It would be difficult to prove on the standard "but for" test of causation for one defendant, since non-immunization of just one child in a community is not likely to lead to an outbreak and widespread infection. In the regular case, it is not simply one individual responsible, but a number of children, the number contributing being the percentage that breaks down the barrier provided by herd immunity. Given that these numbers can be estimated, and that the percent vaccine coverage required to protect against highly infectious diseases such as measles can be as high as 94%,[32] it is possible that in some cases there may be quite a small number of parents who contributed to the outbreak by negligently exposing other children to their infected non-immunized child. In finding

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tion and suffers mental distress, it would not be recoverable.

[31] The "thin skull" rule: *Smith v. Leech Brain*, [1962] 2 Q.B. 405, [1961] 3 All E.R. 1159 at 1161.

[32] Centers for Disease Control and Prevention, "History and Epidemiology of Global Smallpox Eradication. Accessible", online: CDC <http://emergency.cdc.gov/agent/smallpox/training/overview/ppt/eradicationhistory.ppt> at slide 17.

tort liability, unless evidence to the contrary is adduced by a defendant, an inference of causation may be drawn despite the absence of positive proof of medical causation.[33]

Epidemiological data reveals that outbreaks do not occur where people are substantially immunized. The curves constructed from this data show that prevalence of communicable diseases decreases when vaccinations are available and widely used. When vaccine coverage drops, vaccine-preventable diseases return (Figure 2).

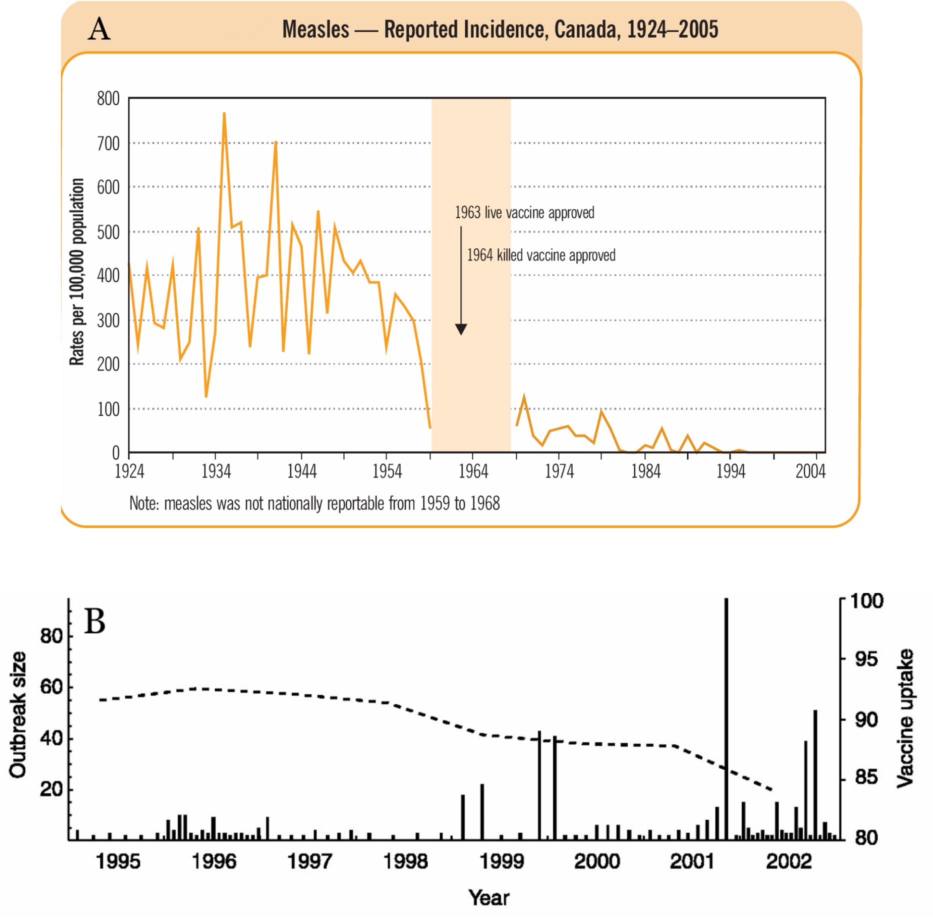

Figure 2: Measles vaccine and reported incidence of measles cases. A) Live measles vaccine was introduced in 1963, and killed measles vaccine in 1964. This innovation helped to reduce cases of measles to almost zero, and prevented new outbreaks of the disease.[34] B) The dotted line indicates dropping MMR vaccine uptake in England and Wales.[35] Note the dramatic increase in outbreak frequency and size once the coverage has dropped below a critical point in the population.

Similar results have been seen with other vaccine-preventable illnesses (Figure 3). In Japan, pertussis vaccine coverage dropped from 90% to less than 40%, after two infants died following DPT immunization.[36] The marked drop in vaccine coverage contributed to the increase in num-

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[33] *Snell v. Farrell*, [1990] 2 S.C.R. 311, 72 D.L.R (4th) 289 at 330; *Sindell v. Abbott Laboratories*, 26 Cal. 3d 588 (1980).

[34] From *Immunization Guide*, *supra* note 2 at 229. One may note that the levels of measles declined prior to introduction of the vaccine; improved hygiene and medical knowledge aided in the reduction of infectious diseases, but the vaccine ensures that resurgence of the disease is prevented.

[35] From V.A.A. Jansen *et al.*, "Measles Outbreaks in a Population With Declining Vaccine Uptake" (2003) 301:5634 Science 804. This 2003 paper predicted a possible re-establishment of endemic measles in the U.K., which has now actually occurred.

[36] *Immunization Guide*, *supra* note 2 at 31.

ber of pertussis cases each year in Japan, which rose from between 200 and 400 cases, to 13,000 cases between 1976 and 1979. Over 100 of these cases were fatal. Similarly, in Ireland, allegations of a link between immunization and autism led to a drop to 76% measles vaccine coverage. Several children died from measles complications when the number of measles cases increased from 148 in 1999, to 1200 in the year 2000, following the decreased vaccine coverage.

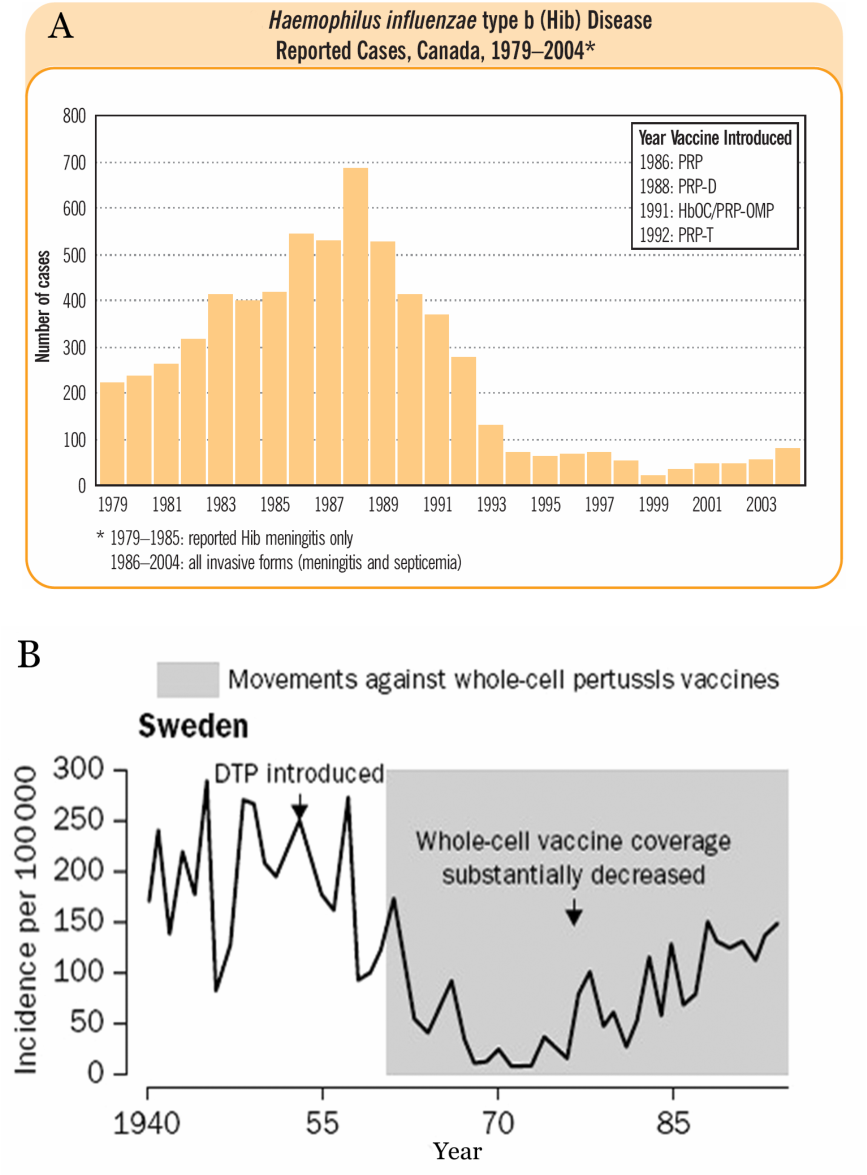

Figure 3: Effects of vaccination on incidence rates of other vaccine-preventable diseases. A) *Haemophilus influenzae type b* cases have been dramatically and sustainably reduced after introduction of the Hib vaccine.[37] B) Movements against whole-cell pertussis (whooping cough) vaccines in Sweden have led to a substantial decrease in vaccine coverage, which in turn have led to climbing incidence rates of the disease.[38]

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[37] From *Immunization Guide*, *supra* note 2 at 173. *Hib* was, prior to the introduction of the vaccine, the most common cause of bacterial meningitis and was a leading cause of other serious invasive infections in young children.

[38] Adapted from E.J. Gangarosa *et al.*, "Impact of Anti-Vaccine Movements on Pertussis Control: The Un-

These diseases have almost been eradicated thanks to routine immunization and high levels of societal compliance with these practices. While it is possible that a single individual might reintroduce a disease, recurrence is highly improbable unless there are pockets of unimmunized individuals; this geographical clustering is likely when groups of parents have chosen to forego vaccinations. If there is a small community of parents who did not immunize their children, then collectively they are most likely the cause of the outbreak and the resulting damage. "But for" the actions of all of these individuals together, the outbreak would not have occurred; yet fault for the outbreak cannot be pinned on any particular individual using the logic of the "but for" test. Thus there may be problems with applying the "but for" test due to the nature of herd immunity, as exceptions to the test are of an extremely limited nature.[39]

However, this problem can be surmounted using the "material contribution" test, the application of which was recently clarified by the Supreme Court of Canada in *Resurfice Corp v. Hanke*.[40] In *Resurfice*, the Court found that the "material contribution" test may be used in place of the "but for" test when two criteria are met:

> First, it must be impossible for the plaintiff to prove that the defendant's negligence caused the plaintiff's injury using the "but for" test. The impossibility must be due to factors that are outside of the plaintiff's control; for example, current limits of scientific knowledge. Second, it must be clear that the defendant breached a duty of care owed to the plaintiff, thereby exposing the plaintiff to an unreasonable risk of injury, and the plaintiff must have suffered that form of injury. In other words, the plaintiff's injury must fall within the ambit of the risk created by the defendant's breach.[41]

Crucially, the Court held that the material contribution test could be applied to cases in which uncertainty arises over which of several defendants was responsible for a given injury. In such cases, as long as *one* of the defendants was surely the cause of the plaintiff's injuries, and as long as *all* of them were negligent, then the "material contribution test" could be used to impose liability, given the impossibility of proof under the "but for" framework.[42] In cases which fall within this category, *restitutio in integrum* should favour the plaintiff who has been injured, but cannot prove conclusively which negligent defendant actually caused the injury. In Britain, this approach has already been used to hold a group of defendants liable for provoking cancer in an employee, even though scientific proof of which defendant caused the injury was impossible.[43] If adopted in Canada, this approach would empower the victim, who has done nothing wrong, to succeed over a defendant who has wrongly exposed him to harm by materially increasing the risk of illness.

Since herd immunity relies on a very high percentage of immunization within a community, the material contribution test may allow for recovery against the discrete group of defendants who have chosen not to vaccinate their children. Measles has a clear epidemic threshold level, where a precise quantitative relationship exists between the infection attack rate during a major outbreak, and the number of susceptible individuals in excess of this threshold.[44] When this level is reached, even in highly vaccinated populations, nearly two additional infections are associated with each susceptible individual above the threshold point (Figure 4). Because of this scenario, a

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told Story" (1998) 351:9099 The Lancet 356.

[39] See e.g. *Cook v. Lewis*, [1951] S.C.R. 830.

[40] 2007 SCC 7, [2007] 1 S.C.R. 333, 278 D.L.R. (4th) 643 [*Resurfice*].

[41] *Ibid.* at para. 25.

[42] *Ibid.* at para. 27.

[43] This succeeded in the "toxic tort" House of Lords case of *Fairchild v. Glenhaven Funeral Services* [2002] U.K.H.L. 22, [2002] 3 All E.R. 305, (Fairchild was exposed to asbestos by multiple employers, and developed mesothelioma, yet it could not be scientifically proven which one had caused the disease; rather than deny compensation to Fairchild, it was determined that all of his employers were liable on the basis of materially contributing to his risk of asbestos-related injuries).

[44] Wallinga, Heijne & Kretzschmar, *supra* note 25 at 1152.

few individuals could be deemed to have contributed substantially to the risk of outbreak through their actions.

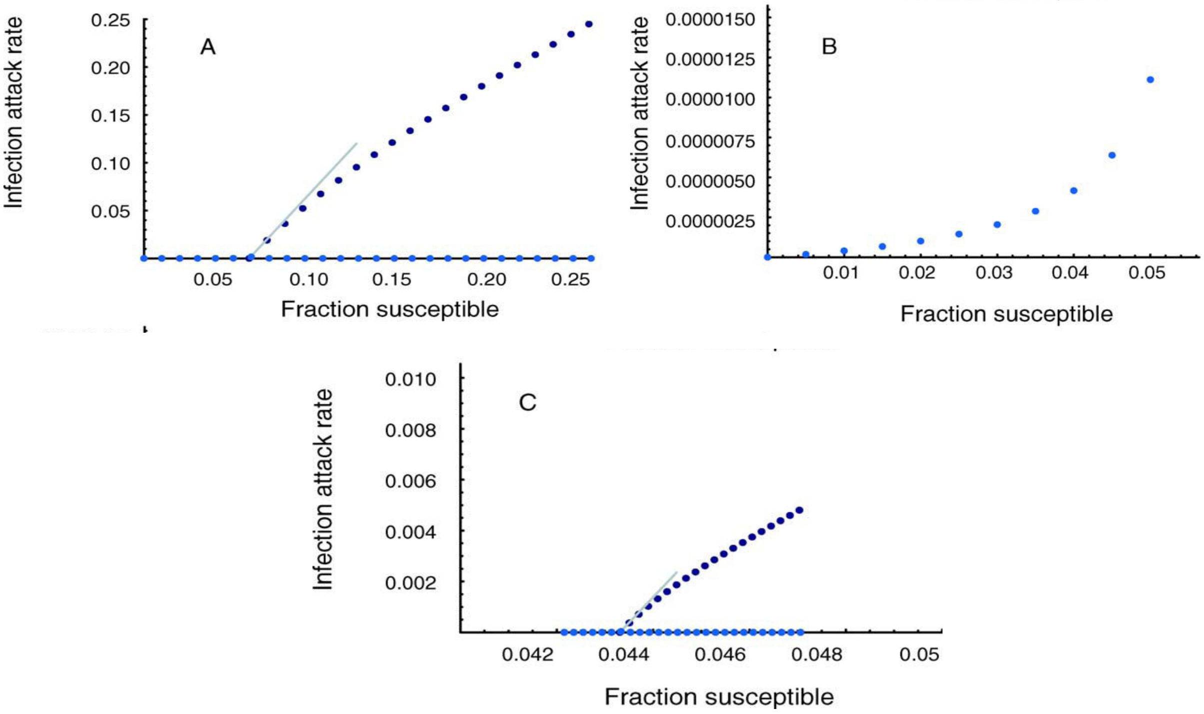

Figure 4: Adapted from Wallinga, Heijne & Kretzschmar, *supra* note 25. Expected infection attack rates during measles outbreaks in A) an idealized homogeneously mixing population, B) in a population protected by solid herd immunity and C) in a heterogeneous population, consisting of a small community embedded in a larger population. There is a clear threshold level for the fraction of susceptible individuals, near 0.043, above which major outbreaks are much more likely to occur.[45]

These individuals would be collectively responsible for the outbreak and as such could be sued as joint defendants. In most cases it would be very difficult to demonstrate that a measles infection arose from a single person. It is possible, however, to find connections between school outbreaks and the number of philosophical and religious exemptors in the community. It is also possible to identify exempt individuals as the source of a transmission. For example, in one study, at least 11% of vaccinated children who acquired measles in outbreaks in Colorado were infected through contact with an exempt child identified as the source.[46] Increased exemption rates show a correlation with an increased number of school-based outbreaks; for schools with outbreaks, the mean exemption rate was 4.3%, compared with a 1.5% mean exemption rate for schools which did not experience outbreaks. While the risk of contracting measles was found to be elevated in personal exemptors, the more important finding is that their presence in large numbers also creates the potential for increased outbreaks in the community overall, a risk that parents may not be aware of when deciding not to vaccinate. On these facts, it appears that each individual decision not to vaccinate a child materially contributes to the emergence of a measles outbreak in a school, which would not likely have occurred otherwise. If these medically unsupported decisions had not been made, the vaccinated child would not have developed measles.

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[45] *Ibid.* at 1155.

[46] Daniel R. Feikin *et al.*, “Individual and Community Risks of Measles and Pertussis Associated with Personal Exemptions to Immunization” (2000) 284:4 Journal of the American Medical Association 3145 at 3148.

Applying this causation analysis to the question of remoteness, it can also be concluded that there is a proximate and foreseeable link between the decision of a small group of individuals not to vaccinate their children, and the development of measles in those vaccinated children or in a nearby vaccinated child.

C. Standard of Care

Establishing whether a single parent or group of parents breached a recognized standard of care is likely to be a particularly challenging obstacle. Categorizations of wrongdoing are based on an objective standard; the reasonable person avoids creating a foreseeable risk of injury to others.[47] Thus, reasonable persons who believe their actions to be in the best interests of their children should also avoid causing harm or creating substantial risks of harm to other children through their actions. Since the reasonable person is independent of the idiosyncrasies of the particular defendant in question, their personal views on the "right" course of action in the situation are irrelevant. What standard of care is owed to the community? In the case of immunization, the answer to this question depends on the reasonably foreseeable consequences of failure to immunize. It seems foreseeable that the failure to immunize a child could result in that child developing an otherwise avoidable disease. What is less clear is whether parents could foresee that the decision not to immunize their child would potentially place other children, immunized or not, at risk.[48]

Creating a risk is only considered negligent if it is a substantial risk, that is, one that is likely to result in harm, or one that could result in especially serious harm.[49] Even where the probability of injury is small, a loss will be recoverable where the extent of harm is so great, were it to materialize, that the reasonable person would act to prevent it.[50] Another factor involved in determining whether a risk is reasonable is how advantageous the act is, in comparison with the negative effects associated with taking the risk.[51]

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[47] Philip H. Osborne, *The Law of Torts*, 3d ed. (Toronto: Irwin Law, 2007) at 30.

[48] Exposing others to a risk of disease as a result of negligent practices has been shown to be actionable. For example, the Canadian Red Cross Society has been held liable for negligently screening blood donors with HIV, leading blood recipients to become infected. See *Walker Estate v. York Finch General Hospital*, 2001 SCC 23, [2001] 1 S.C.R 647, 198 D.L.R. (4th) 193.

[49] *Bolton v. Stone,* [1951] A.C. 850, U.K.H.L. 2. For example, children who have never been immunized due to allergy to vaccine components could be particularly susceptible to vaccine-preventable diseases, and greater care might be expected with these individuals.

[50] *Overseas Tankship (U.K.) Ltd. v. Miller Steamship Co. Pty (The Wagon Mound No. 2)*, [1966] 2 All E.R. 709, 3 W.L.R. 498 (P.C.). If the burden of eliminating the risk of serious harm is minimal, and not taken, the action or non-action will be more likely to be deemed unreasonable. There could be considerable debate as to whether the burden of mandatory vaccination is minimal, as it inherently requires assumption of some personal risk of physical adverse reaction, which can potentially be quite serious in very rare cases.

[51] Angus Dawson, "Herd Protection as a Public Good: Vaccination and our Obligations to Others" in Angus Dawson & Marcel Verweij, eds., *Ethics, Prevention, and Public Health* (Oxford: Oxford University Press, 2007) 160. There is an ethical argument that creating herd immunity through vaccination is an important public good of such significance that there is a moral obligation on individuals to participate in vaccination programs. However, Dawson argues that once herd protection is established in a population, the moral obligation to participate is no longer present and there may be valid reasons to opt out. This argument would seem to hold as long as herd immunity remains constant and certain; by receiving vaccination at this point a person would be taking on a risk in a situation in which no additional benefit would be brought about to others. However, this argument would only work if a very small number of people took this position. The problem is that if a large enough number of people subscribe to this view and choose not to vaccinate, herd immunity will be lost and the rationale will be undermined. We would counter, then, that the moral obligation remains to continue vaccination programs for the public good because of the importance of maintaining herd immunity. This position is bolstered by findings that herd immunity is lost in populations with clusters of unimmunized individuals, leading to an increase in the number of outbreaks. For more on this point see Omer *et al.*, "Vaccine Refusal", *supra* note 4.

The scientific literature indicates that immunization is a socially and personally beneficial activity, and many of the perceived dangers associated with vaccination have not been substantiated.[52] Thus it can be argued that claiming a non-medical exemption to routine vaccination is not a beneficial activity, neither for the child nor for society. It can in fact be considered a harmful activity, as non-vaccinated children increase the risks of disease exposure and transmission. The positive aspects of vaccination and the negative aspects of non-vaccination militate in favor of imposing a stricter standard of care.

The imposition of a new standard of care poses several questions. The first is whether parents could be held liable for discrete actions, aside from the initial decision not to vaccinate, which increase the risk of outbreak in the community. As an extreme example, a parent of a non-immunized child could conceivably be perceived to have broken a standard of care if the child, after being in a region with a known outbreak of the communicable disease for which the refused vaccine was intended, is then brought into the company of other community children, despite first displaying symptoms of the disease.[53] If, in such a situation, another child in close proximity contracted the disease, and developed a serious case of encephalitis resulting in permanent damage, there would be a fairly good case that the non-immunizing parents breached a standard of care, and were causally responsible for the injury. A reasonable person would have recognized the substantial risk involved, particularly because the child was unimmunized. Relevant governing bodies strongly recommend immunization when traveling to certain areas of the world, and travel advisories are released to the public.[54] Global travel has increased the possibility of importing diseases into Canada, including those which are no longer found endemically in this country.[55] In cases of endemic communicable diseases, such an argument may also apply in cases where the travel is not abroad, but simply to a local area of high disease prevalence.

One could posit that the reasonable person would act to reduce risk by conforming to standard routine immunization practices and updating immunization with required vaccinations for travel. Failure to take care in these circumstances may arguably endanger the Canadian population in general, and could be considered not just a matter of health policy, but also of health security. Although such recommendations are not binding law, they could be used in court as strong evidence of the level of care expected of Canadians who travel abroad. Assuming that measurable damages occurred and a causal link can be established, a novel claim in negligence could possibly succeed against parents who chose not to immunize their children prior to travel-

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[52] See Christopher B. Wilson & Edgar K. Marcuse, “Vaccine Safety—Vaccine Benefits: Science and the Public’s Perception” (2001) 1:2 Nature Reviews Immunology 160.

[53] This situation may seem far-fetched at first glance. However, these scenarios are in reality becoming more common as a result of the increase in parental resistance to immunization, especially within close-knit social groups. In 2005 in Indiana, a 17-year-old unvaccinated girl brought measles back to the U.S. on return from a trip to Romania, leading to the largest documented measles outbreak in the U.S. in a decade. Transmission was magnified as the girl was sent to attend a church gathering of 500 persons the day after she returned home, despite the fact that she was exhibiting prodromal symptoms. Many individuals at the gathering were unvaccinated, including young children. This incident led to hospitalizations and some complications, but luckily, no serious adverse effects or deaths. However, there is no guarantee that such events in the future will be as benign. It is important to note that 94% of the patients with confirmed measles were unvaccinated. There is a reasonable argument that the parents of this teenager breached a standard of care by exposing the public, and especially a largely unimmunized sector, to their unimmunized daughter, who had recently traveled abroad and was showing symptoms of illness. This example reveals that the issue is highly relevant today. See A.A. Parker *et al.*, “Implications of a 2005 Measles Outbreak in Indiana for Sustained Elimination of Measles in the United States” (2006) 355:5 New Eng. J. Med. 447.

[54] Such as *Immunization Guide*, *supra* note 2.

[55] Health Canada, “It’s Your Health: Travel Health”, online: Health Canada <http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/life-vie/travel-voyage-eng.php> (to protect oneself from the health risks of travel, one is advised to ensure that routine vaccinations are completed and up-to-date, and if necessary to immunize against other diseases, depending on the location).

ing to a high-risk area. If the disease contracted by immunized or medically-exempted children has been virtually eradicated in this country, then a convincing chain of transmission can likely be traced to those who have recently traveled to an area where the disease is present.[56] Thus, it is possible that in some situations, actions taken that expose others to an unreasonable risk of contracting a contagious illness may be considered a breach of the expected standard of care. Of course, this depends on the weight given to the force of health recommendations, and the expectations of Canadians in following these recommendations.

Public health considerations lead to a second and more difficult question: can the choice not to immunize a child in itself be considered an unacceptable level of risk to impose on others? This engages considerations that arise much earlier, namely whether a citizen must vaccinate his child as an infant or small child to conform to a Canadian standard of care. At present, the answer to this question is not clear for parents who are looking for reparations for harm caused to their children by vaccine-preventable illnesses from those who have caused an outbreak. The standard of care represents what the reasonably prudent person would do. It is a convincing argument that the reasonable and careful parent would immunize against common communicable diseases, despite the small risk of adverse reaction. It is customary practice in Canada to vaccinate, and the overwhelming majority of the country follows the guidelines strongly emphasized by national and international public health bodies; although standard practice is not binding, it can be used as evidence of the standard of care.[57] The courts have historically shown deference to the medical profession and health practices, determining the reasonable standard of conduct in accordance with accepted customary practice.[58] Vaccination is a long-established customary practice in Canada, despite being optional.

The immunization program is, however, according to current rules, a personal choice made by parents and is not mandated by the government, though regulations are implemented to encourage a high level of compliance.[59] As there is no "tort of selfishness" in our country, parents of children harmed by a disease outbreak would be unlikely to succeed. The best argument to improve their chances of success is that the standard of care should be made more rigorous, such that Canadian citizens would be required to implement prudent prophylactic measures to protect against communicable diseases.[60]

The issue within the standard of care analysis that requires attention from public health officials is whether or not parents are aware of the consequences of their choice not to immunize. The risks must be adequately communicated to parents in order to establish that they could be breaching a standard of care. For many diseases, such as measles, there is no doubt about the efficacy and importance of vaccines. Data shows that many devastating diseases of the past have declined drastically in prevalence since the introduction of routine immunization programs.[61] These programs have as their goal the national and worldwide eradication of diseases, and not simply personal health protection. However, information sources and promotional literature for parents, such as those provided by the Ontario Ministry of Health and the Canadian Pediatric

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[56] The SARS outbreak in Toronto is illustrative of this phenomenon: Priya Sampathkumar *et al.*, "SARS: Epidemiology, Clinic Presentation, Management, and Infection Control Measures" (2003) 78:7 Mayo Clinic Proceedings 882.

[57] See Osborne, *supra* note 47 (established practice is useful evidence for a court to consider, as it represents a "concrete, defined course of conduct that reflects the accumulated wisdom of those involved in the activity" at 36).

[58] *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674, 127 D.L.R. (4th) 577 at 693.

[59] See Public Health Agency of Canada, "Vaccine Safety", online: PHAC <http://www.phac-aspc.gc.ca/im/vs-sv/index-eng.php>.

[60] Of course this standard would include, to honour *Charter* rights, exemptions for medical reactions to vaccination and for bona fide religious beliefs that prohibit vaccination: *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[61] See *Immunization Guide*, *supra* note 2.

Society, stress the benefit for *your* child's health, rather than for the benefit of community health.[62] Thus, it may be difficult to establish, even if immunizations were mandatory, that a parent "ought reasonably to have had in his contemplation" the well-being of others when the public literature indicates that it is a personal choice for the health of your child, rather than a standard procedure for the health of all children.[63] Under the *Immunization of School Pupils Act* schools in Ontario require immunization, or an official exemption, before pupils may enroll.[64] Parents must vaccinate their children and there is a $1000 fine for non-compliance. This is not done for the benefit of each child; schools do not generally inquire into the well-being of each pupil. Rather, it is for the societal protection associated with vaccines: the well-being of all of the children. This requirement is a strong indicator that the reasons for vaccination are not personal but rather communal, and can serve as evidence of the reasonable standard which is expected of Canadians.

In New Brunswick, under the *Education Act*,[65] a student must also provide proof of required immunizations, subject to similar exemptions. While Manitoba had an analogous provision, it was repealed in 1999.[66] Other provinces do not have specific acts dealing with the issue, although schools may request an immunization record and there may be repercussions for those not meeting the provincial vaccination lists.

Immunization practices for the general public are strongly recommended in Canada, the U.S., and in virtually every country around the world.[67] There are essentially no dissenting views at the appropriate levels of regulation and public health leadership.[68] The result is that children in those provinces and states implementing these policies must be vaccinated or officially exempted in order to legally attend school. Although home-schooled children are not legally required to be vaccinated, there have been calls for changes to this policy, as it leaves those children and others in the community in danger of contracting preventable diseases.[69] The same problem applies to provinces with voluntary vaccination schedules for school children.

While the majority of the population adheres to voluntary immunization according to the prescribed schedule, this may not be enough to determine what parents "should" have done. The

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[62] Canadian Pediatric Society, "Immunization: Vaccination and Your Child" in *Caring for Kids*, online: CPS <http://www.caringforkids.cps.ca/immunization/vaccinationchild.htm>; Ontario Ministry of Health and Long-Term Care, "Immunization: Your Best Protection", online: MOHLTC <http://www.health.gov.on.ca/english/public/pub/immun/immunization.html>.

[63] The "neighbour" principle as formulated by Lord Atkin in *Donoghue v. Stevenson*, [1932] A.C. 562, S.C. (H.L.) 31 at 580. It can be argued that a reasonable parent would only have considered the health of her own child, rather than the health of other children.

[64] R.S.O. 1990, c. I. 1., s. 3 [*Immunization Act*].

[65] S.N.B. 1997, c. E-1.12, s.10.

[66] The act which was repealed in 1999 was the *Public Schools Act*, Re-Enacted Statutes of Manitoba 1987, c. P250 at s. 261(1).

[67] See the World Health Organization, "Global Immunization Vision and Strategy", online: WHO <http://www.who.int/immunization/givs/en/index.html>.

[68] While there is an acknowledgement that vaccination does pose some risks, there is consensus amongst most public health officials that for recommended childhood vaccines serious risks are exceedingly rare and the benefits of immunization outweigh the risks posed to the child. Perhaps the most high profile of these vaccination controversies has been the link between thimerosal and the development of autistic spectrum disorders. While initially health officials called for a removal of thimerosal from childhood vaccines on precautionary grounds, subsequent epidemiological studies failed to show an association. The U.S. Court of Federal Claims has adjudicated over three test cases purporting a link between vaccines and autistic spectrum disorder and rejected all three. Of note, the necessary evidentiary level for justifying compensation within these courts is less than the level in a civil court: United States Federal Court of Claims, "The Autism Proceedings", online: USCFC <http://www.uscfc.uscourts.gov/sites/default/files/Hazlehurst_ Affirmance.pdf>.

[69] See Danya Khalili & Arthur Caplan, "Off the Grid: Vaccinations Among Homeschooled Children" (2007) 35:3 J.L. Med. & Ethics 471.

fact that immunization requirements are not standardized throughout the country, combined with the lack of information about the broader societal risks of the choice, presents a major barrier to establishing a higher standard of care. Parents may not know, or claim not to know, the risks posed to other children by choosing not to vaccinate their own children. In some cases, they know of the risks but declare that they are unwilling to "sacrifice" their child for the greater good.

Although it is not necessarily negligent to try to save oneself at the risk of another, this determination may depend on the quality and nature of the information one is acting on. In this type of situation, the parent is assuming a risk and could conceivably be held responsible if that risk materializes. However, the exemption affidavit form for conscience or religious beliefs mentions only that the signatory understand that a pupil may be excluded from school if there is an outbreak of disease.[70] It does not mention the particular risks posed to other children of actually causing an outbreak of disease due to lack of immunization. Allowing conscientious objections to vaccination compromises the important goal of eradicating infectious diseases. This problem should be dealt with more thoroughly by public health authorities; at a minimum, individual parents should be made aware of the communal consequences of declining vaccinations.

D. Duty of Care

Establishing the duty of care is generally considered the primary instrument of control over the extent of negligence liability.[71] There is no such thing as "negligence in the air"; that is, negligence is not a tort unless it results in the commission of a wrong which causes the violation of a protected right.[72] A plaintiff seeking to recover in tort must show that damage occurred, but also that a duty was owed to him by the negligent defendant not to cause him harm. Thus the relationship in question must be identified before one can assess the potential for liability. Certain relationships have been identified by the common law as leading to a duty of care, while others have not been specifically examined in previous cases. Where an unrecognized duty of care is proposed, the three stage Anns/Cooper test is used to assess whether the law of negligence may be extended to a new situation or be used to create a new cause of action.[73]

The relationship between non-immunizing parents and the children to which their non-immunized children are exposed will likely be considered a novel one for the courts, not falling within or closely analogous to a recognized category of relationships where a duty of care has been found. If faced with this problem, the Anns/Cooper test would likely be implemented.[74] The outcome of this test would be central to establishing whether a plaintiff has the right to make a claim, as it defines the scope of liability. In the first part of the investigation, a prima facie duty of care would be found if the harm suffered was reasonably foreseeable, and there was sufficient proximity between the parties.[75] If such a prima facie duty were found to exist, the court would then ask if any residual policy considerations might limit or negative that duty.[76]

The first stage of the test is foreseeability, which is necessary but not sufficient to establish a prima facie duty of care. Here, we contemplate three separate scenarios. (1) If the disease is clinically manifest during the infectious period, responsibilities would be no different for an immunized child versus an unimmunized child. In this situation, it is entirely foreseeable that

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[70] This is the case in Ontario, with similar forms in New Brunswick and the U.S.

[71] Osborne, *supra* note 47 at 67.

[72] *Palsgraf v. Long Island Railroad Co.,* 248 N.Y. 339, 162 N.E. 99 (1928) at 345.

[73] *Cooper v. Hobart*, [2001] 3 S.C.R. 537, 206 D.L.R. (4th) 193 [*Cooper*]. The Anns test, from *Anns v. Merton London Borough Council,* [1977] 2 All E.R. 492, [1978] A.C. 728 was adopted by the SCC in *City of Kamloops v. Nielsen,* [1984] 2 S.C.R. 2, 10 D.L.R. (4th) 641.

[74] *Cooper*, *ibid.*

[75] *Ibid.* at para. 31.

[76] *Ibid.* at para. 37.

an infected child could transmit a communicable disease to an uninfected child. (2) It is less foreseeable that an unimmunized child could develop a vaccine preventable condition and then transmit this condition, while infectious but *not clinically symptomatic*, to a child who could not be immunized. (3) It is perhaps even less foreseeable that an unimmunized child could develop a vaccine-preventable condition and then transmit this condition to a child who is immunized; however, the scientific basis for this mode of transmission is understood. Whether the second and third cases would be considered foreseeable would depend on the likely knowledge of the parent.

Parents can be expected to know that infectious diseases are transmissible. And even though they may disagree, they are informed by their health care providers, or through the exemption form that they sign, that not immunizing their children places them at greater risk for developing vaccine preventable diseases. What the parent is less likely to be aware of is that some children cannot be immunized and that even if immunized, one may still develop a vaccine-preventable disease. Still, large measles outbreaks are far more likely in populations which decline vaccines. Non-immunizing parents would be aware of the increase in infectivity resulting from such a decline in uptake if the authorities have made them aware of this fact during the opting-out process. This would have to be done in a manner that is comprehensible to parents, for example informing parents that the decision they are making may place other children at risk of developing potentially serious illnesses. If this type of information transfer were implemented, it could shift, in the minds of parents, the scenario of an outbreak into the realm of foreseeability.

The second stage of the Anns/Cooper test is proximity, that is, whether there is a relationship of sufficient closeness and directness which, upon examination of policy factors pertaining to the relationship, makes it fair and just to impose a duty of care in the context.[77] Proximity can be implied by physical, social, and causal closeness. The court must be satisfied that the plaintiff is a foreseeable victim, or a member of a class of foreseeable victims. This would likely be met by children who are in schools or day care facilities with the defendant's child.[78] A close and direct relationship would surely arise in a situation of prolonged and direct physical contact between a non-immunized child and another child, particularly in the setting of an educational institution. A policy factor which would tend to limit the duty at this stage is the wide range of persons to whom the infectious child would be exposed; the plaintiff must be able to show that he belonged to a particular identifiable group owed a duty of care by the defendant. There is a strong argument then that, at least at this stage of the test, a duty should be imposed on parents who choose to send their unimmunized children to after school programs, play dates, or arguably day school, depending on the statutory authority barrier, which will be discussed below. Because infection in such close quarters would be both foreseeable and proximate, it seems likely that a prima facie duty of care would be imposed.

The third stage of the test involves residual policy factors relating to the impact of imposing a duty on society, legal obligations, or the legal system in general.[79] The implications of finding a duty in this case could be far-reaching, in that it would require a child to undertake a personal physical risk to avoid causing a larger risk to others. Balancing policy concerns with individual rights would be an integral aspect of the policy analysis. A judge may not be willing to impose such a duty on parents, given their role as guardians and decision-makers in their children's

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[77] *Ibid.* at para. 37.

[78] Patricia Peppin, "Vaccines and Emerging Challenges for Public Health Law" in Tracey M. Bailey, Timothy Caulfield & Nola M. Ries, eds., *Public Health Law and Policy in Canada* (Markham: LexisNexis Butterworths, 2005) 133 at 147.

[79] Osborne, *supra* note 47 at 68.

lives. However, the judge would also take into account the difficulties posed to a parent who is harmed by those decisions, which may be made without full information.

In the case of *Dobson*, it was determined that although a prima facie duty of care exists between a mother and her injured unborn child, it cannot be imposed for reasons of public policy.[80] This case holds some relevance to the situation under consideration as it shows that the courts have indicated a need for restraint where a change in the law would affect sensitive and far-reaching issues of public policy. In many ways though, this situation is different. The policy decision in *Dobson* seems to have been guided mainly by the nature of pregnancy and the closeness of that relationship. This is not easily transferable to the case where a person's "lifestyle" choices harm a child not only outside of the womb, but also from another family altogether. The risk of harm posed is serious and potentially violates the rights of children to be protected from ill health. Still, the situation is in a similar vein to *Dobson*, in that holding parents negligent for failing to immunize their children may be considered too far a reach into the private and personal actions of citizens. When immunization is at issue, the autonomy rights of parents to make decisions about their children's medical care come up against the rights of other children to be protected from preventable dangers. These types of issues are often characterized as beyond the jurisdiction of the court and better left for Parliament. Immunization practices raise their own complex constellation of public policy issues, and these must be weighed along with the importance of individual autonomy in medical consent and parental choice.

An important caveat to the tort analysis is that the duty of care usually relates to malfeasance, or acting wrongly, rather than to nonfeasance, or failure to act.[81] Harm can in fact result from failure to perform an action, although negligence law does not normally oblige a person to confer a benefit on others. However, there is a growing list of exceptions that give rise to affirmative, positive duties in certain special relationships.[82] The Supreme Court of Canada in *Childs v. Desormeaux* envisions the imposition of positive duties of care upon three classes of defendants: those who create risks and invite others to participate in them; those who exercise "paternalistic relationships of supervision and control"; and those who "offer a service to the general public that includes attendant responsibilities to act with special care to reduce risk".[83] The failure to immunize best approximates the first "creation of risk" class. In some cases, there is a duty to rescue others from situations of danger.[84] Thus, one possible future direction for this area is the imposition of a duty to act, to receive immunizations or mitigate exposure, thus "rescuing" others from infectious disease. This duty, as stated in *Childs*, would arise from "the defendant's causal relationship to the origin of the risk of injury faced by the plaintiff," and here the causal chain runs from the defendant's failure to vaccinate to the plaintiff's subsequent infection.[85] The courts are, however, reluctant to impose an obligation of rescue. In the court's analysis, it would be relevant to examine the degree of risk posed to the defendant in taking this action, including the risk of adverse effects from the vaccine, and the degree of uncertainty attached to the scientific knowledge, before concluding that such a duty to rescue exists.[86]

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[80] This is due to the unique nature of the maternal-fetal relationship and the impossibility of allowing negligence claims based on injury during pregnancy without trespassing on the privacy and autonomy rights of women (see *Dobson*, *supra* note 3).

[81] Osborne, *supra* note 47 at 73.

[82] *Childs v. Desormeaux*, 2006 SCC 18, [2006] 1 S.C.R. 643 [*Childs*].

[83] *Ibid.* at paras. 35-37.

[84] *Horsley v. MacLaren,* [1972] S.C.R. 441, 22 D.L.R. (3d) 545 (this case concerns the tort consequences to a ship owner for failing to rescue a passenger who had fallen overboard).

[85] *Childs, supra* note at 82 at 35.

[86] Bailey, Caulfield & Ries, *supra* note 78 at 147.

E. Damages

To establish negligence liability, harm caused must be actual and compensable by damages.[87] Physical damage is the prototypical type of recoverable harm. If a child contracts a disease against which he is immunized, the harm caused is likely to be minimal, as the immunization will either fully protect the child or attenuate the severity of symptoms. Effective management of disease symptoms is generally possible; thus, only in rare cases will an immunized child have a legal claim. However, the law emerges from exceptional cases, and it is possible that a claim could arise from an immunized child who contracts a vaccine-preventable illness from a negligent exposure, and incurs permanent or sustained harm. Such results are a distinct possibility with the measles virus, which can progress into serious and even fatal complications, including encephalitis and pneumonia.[88] The situation may be more probable, and more severe, in cases where the child infected is one who cannot be immunized as a result of contraindication due to medical conditions or allergy. This category of child relies on herd immunity for protection from dangerous childhood diseases, and could suffer significant damages which would be compensable.

III

DEFENCES FOR FAILURE TO IMMUNIZE

A significant and possibly insurmountable barrier to plaintiff recovery in court, when dealing with exposure within schools, is the defence of statutory authority. Ontario's *Immunization Act* requires immunization according to a prescribed schedule to attend school, but explicitly allows exceptions to those who file a statement of medical exemption, or a statement of conscience or religious belief.[89] Such exemptions are being used increasingly frequently in the U.S. and Canada.[90] The Canadian provinces which require immunization for school entrance provide an option for non-immunization. Other provinces do acknowledge the importance of immunization programs, providing funding for immunization clinics and promotional literature, but do not make it mandatory for children to be immunized in order to enter school.[91] Thus, either a parent is given explicit authority not to immunize, or implicit authority not to immunize based on the absence of strict requirements. The defence of statutory authority states that defendants cannot be held liable in negligence for their actions if there is legal authorization for the action or non-action in question, unless that action or non-action was *executed* negligently.[92] Thus, as long as parents who refuse to vaccinate based on personal beliefs follow the policy, they cannot be penalized simply for taking the exemption, as the government has already said that this was an acceptable choice.

However, the law is only permissive. If the exemption is taken but the parent still acts negligently, for example sending an unvaccinated child who has recently been in an area of outbreak to school despite clear warning signs of contagion, the possibility for an action in negligence could still remain. In such a case, the choice not to immunize itself would not be negligent, but rather negligence would derive from the exposure of that child in a situation where there was a likelihood of infecting others, including those who are particularly susceptible. The statutory au-

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[87] John G. Fleming, *The Law of Torts*, 9th ed. (Sydney: LBC Information Services, 1998) at 216.

[88] See Jacqueline Gindler *et al.*, "Acute Measles Mortality in the United States, 1987-2002" (2004) 189:S1 Journal of Infectious Diseases at S69.

[89] *Immunization Act*, *supra* note 64, s. 17(2).

[90] Thompson *et al.*, *supra* note 19.

[91] See e.g. Alberta Health, *Alberta Immunization Strategy 2007-2017* (Edmonton: Communications, 2007).

[92] Although this is normally considered in the context of actions of public authorities, it also applies where a person chooses to pursue a valid option presented by the legislation: *Priestman v. Colangelo,* [1959] S.C.R. 615, 19 D.L.R. (2d) 1.

thority defence would not apply in this situation, and so there may be a less complicated path to hold a parent liable.

The other scenario, in which the choice not to immunize is the only factor responsible for the outbreak, engages more significant statutory authority hurdles. Exemptions to school rules would not necessarily apply outside of school grounds. Much of the close contact between children that results in transmission of communicable diseases occurs after school hours. Furthermore, some children are home-schooled or live in areas without mandatory policies and therefore do not have any official immunization requirements. In these scenarios, there is no statute directing or exempting immunization, but there remains the standard practice of routine immunization, which could still serve as evidence of reasonable behaviour. A person may not be required to vaccinate, but this allowance does not absolve a person of all consequences of choosing not to immunize. This is a complicated area and will be difficult to resolve without changes to the statutory regime on immunization.

Another possible defence is voluntary assumption of risk or the doctrine of *volenti non fit injuria*. It is reasonable to say that parents are assuming some level of risk by sending children to a public school system which allows vaccination exemptions for non-medical reasons. This may not give parents a lot of options, but the choice remains—either through home-schooling or other alternatives. This is, however, a difficult defence to meet, as one must prove an express or implied agreement between the parties, and that the plaintiff has consented to accept both the physical and *legal* risk of injury from the defendant's negligence.[93] It is rare to find a plaintiff who willingly abandoned his right to sue in negligence. Still, life does entail some degree of risk, and contagion by an unimmunized child may be considered by the court to be simply a part of life in light of the fact that exemptions are permitted. This policy ambiguity can likely only be addressed by a change in immunization policy.

CONCLUSION

Litigation has become a popular means of social activism. In this atmosphere, a break in herd immunity may tempt parents of injured children to consider litigation as a way to address the increased risk posed by substantial numbers of parents declining routine immunizations. Still, from a legal perspective, there are certain barriers which may render recovery unattainable. The first is that a single individual could not normally be held causally responsible for the development of an outbreak. It would be impossible to identify which unvaccinated individual either transmitted the virus to a vaccinated child, or was responsible for the breakdown of herd immunity. However, a group of individuals could be found to be responsible for causing an outbreak. It is epidemiologically clear that in the presence of high vaccination rates of an effective vaccine, vaccine-preventable diseases disappear. For successful person-to-person transmission of the virus, and therefore for outbreaks to occur, a discrete portion of the population must be unvaccinated. If such a group is readily identifiable, recovery may become possible. The second major obstacle to determining liability is establishing whether parents have breached a standard of care. This issue will remain difficult to resolve as long as the government maintains its compromise policy of allowing immunization exemptions for conscientious reasons, particularly in the absence of full disclosure of the risks such exemptions create. While public health authorities and governments present vaccination as an individual choice, it is not clear whether those who refuse to vaccinate could be held liable because of the lack of clarity in articulation of the standard of care across and within provinces.

At present, then, litigation is likely not the best forum for this discussion, since the current model is not rigorous enough to categorize those who fail to immunize as negligent. Although

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[93] *Dube v. Labar,* [1986] 1 S.C.R. 649, 27 D.L.R. (4th) 653.

the courts may open a gateway for discussion, the ultimate responsibility lies in the hands of Parliament and public health advocates. The possibility does exist though for governments to create an environment where the assertion that a parent or groups of parents who breached a standard of care could succeed. This would require clear transmission of information to parents that the decision to vaccinate a child is not only for the benefit of the individual child, but also the benefit of other children with whom the child may come into contact.

There remain valid arguments against the imposition of mandatory immunization. Parents would be forced to assume a risk to their child's health by adverse vaccine-related events, which occur in a low but unavoidable percentage of vaccine recipients. Determining which is favourable between competing risks is arguably a parent's determination and not one that should be left to the state. The main concern for parents is that epidemiological evidence can be ambiguous in this area, and needs further study. Nevertheless, it may be within the ambit of government action to ensure widespread protection by imposing mandatory vaccination, especially against diseases like the measles, which are particularly virulent and countered by long-established, high efficacy vaccines. Measles is presently a hot topic, with several recent measles outbreaks in North America attributed to heterogeneous vaccine uptake. While measles has been the focus of this article, the same arguments could apply to other diseases for which there are effective vaccines and in which outbreaks have recently occurred, for example pertussis and mumps. However, the analysis of these scenarios would depend on the scientific characteristics of the specific disease and vaccine and may not be entirely analogous to measles.

The standard of care issue could be clearer if exemption forms were standardized across the provinces, informing those parents claiming a philosophical exemption of the inherent risks of non-immunization. The addition of an unequivocal statement on exemption forms and a signature requirement that the parent is acknowledging the existence of risks to community health by not vaccinating, combined with standardizing school immunization policies across the country, will be an important step toward creating a climate in which private legal action will be more likely to succeed. This statement should highlight the importance of vaccination to the communal health of children, in addition to the health of any particular child, and should make clear the negative community effects of opting out. This would have the benefit of both informing the parents of the possible consequences of their choice, and serving as evidence that it was foreseeable that an outbreak would be increasingly likely to occur with each child unimmunized. Parents making a personal decision not to immunize should be aware that they are increasing the risk to the community. Holding conscientious objectors responsible for their decisions provides an alternative to absolute mandatory immunization, which tends to raise concerns about invasion of bodily integrity and other *Charter* issues.[94]

If philosophical exemptions were removed from school requirements, or if the form clearly explained to parents the risk of non-immunization, this could also deny parents the protection of a statutory authority defence ("choose inaction at your own risk"). In this way, people who so wish can avoid intrusive medical interventions, but will not be "let off the hook" for making a decision which could be harmful to public health. If people choose to claim a non-medical exemption to school immunization requirements, which is currently their prerogative, it can be argued that they are accepting a certain level of risk to others when making this decision. If this risk materializes, it could result in liability. Truthful and straightforward information like this, disseminated through public service announcements, government websites, and exemption forms, could provide a powerful tool for public health to combat the phenomenon of conscientious exemptions based on misinformation. Directly confronting anti-vaccination groups would

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[94] See R. Rodal, N.M. Ries & K. Wilson, "Influenza Vaccination for Health Care Workers: Towards a Workable and Effective Standard" (2009) 17 Health L.J. 297. See also Bailey, Caulfield & Ries, *supra* note 78 at 150.

prove very difficult for the authorities. The tides may turn in the immunization debate in a climate where parents of children who have suffered permanent damage from contracting a vaccine-preventable illness can succeed in court. As was the case with cigarette smoking, the "stigma effect" could substantially reduce the number of parents claiming conscientious objections to vaccination, simply through the power of social disapproval.[95] Further, the dissemination of more balanced knowledge about vaccination may help to convince parents that childhood immunization is the right choice. Parents who conform to the standard practice will be vindicated, and doubt will be cast on the anti-vaccine movement and the threat it poses to public health.

It is the nature of vaccination that as the number of parents making the choice not to immunize increases, the risk of vaccine-preventable disease outbreak increases concurrently. To reverse this trend, it may be necessary to prioritize public health over individual rights to choose medical treatment. The overriding interest in community health and safety could lead to challenges and changes in the non-medical exemptions to school immunization requirements.[96] Parents would likely launch a *Charter* challenge in response to any legislation which mandated compliance with the routine immunization program, though a full discussion of the difficult issues involved in legality of mandatory vaccination is not within the scope of this article.[97] Immunization as a legal, ethical, and policy issue presents unique challenges of balancing the rights of the individual versus the rights of the population as a whole. Respect for individual choice should be perceived as a core consideration in developing public health strategies, but this concern need not compromise the ability of government to protect the health of its citizens.[98]

What we have suggested in this paper is a mechanism by which policy makers could create a scenario where the majority can better protect their rights, while still protecting the rights of the minority. The process of informing parents of the consequences of their decision would not simply be for the end of establishing a legal right, but would also be part of a public health strategy. The reality that other children may be harmed as a result of one's choices could be a powerful factor in the decisions a parent makes about immunization. However, in conjunction with these changes it would be appropriate to ensure protection for those who have concerns about vaccination, for example introducing no-fault compensation programs for vaccine injured children and improving post-market surveillance of vaccine safety and efficacy.[99] Given the essential role

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[95] See Jennifer Stuber, Sandro Galea & Bruce G. Link, "Smoking and the Emergence of a Stigmatized Social Status" (2008) 67:3 Social Science & Medicine 420.

[96] See Linda E. LeFever, "Religious Exemptions from School Immunization: A Sincere Belief or a Legal Loophole?" (2006) 110 Penn St. L. Rev. 1047.

[97] *Charter* issues are hotly debated in the public health context. In some situations, such as abortion, an individual forced to make choices unrelated to her priorities and aspirations violates the *Charter*: see *R. v. Morgentaler* [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385. But in other situations, for example when a parent refuses life-saving treatment for a child based on religious objections, the *Charter* right may be overridden: *Children's Aid Society*, *supra* note 28. The importance seems to be in balancing the positives and negatives of a choice that affects both oneself and the rights of others. What are deemed "lifestyle choices" do not necessarily receive the protection of the *Charter*, especially when they may cause harm: *R. v. Malmo-Levine*, [2003] 3 S.C.R. 571, 233 D.L.R. (4th) 415. In 1905, the U.S. Supreme Court held that requiring vaccination of the general population is within the reasonable exercise of a state's police power, and does not violate fundamental liberty rights: *Jacobson v. Massachusetts* 197 U.S. 11 (1905). The Court stressed that common welfare must sometimes trump an individual's unfettered freedom, which does not include the right to place the health of the community at risk. In a separate case, the Court stated that some state interventions are permissible restrictions on parental authority, including vaccination policies: *Prince v. Massachusetts* 321 U.S. 158 (1944).

[98] J.D. Blum & N. Talib, "Balancing Individual Rights versus Collective Good in Public Health Enforcement" (2006) 25:2 Med. & L. 273.

[99] See Nicole J. Kutlesa, "Creating a Sustainable Immunization System in Canada—the Case for a Vaccine-Related Injury Compensation Scheme" (2004) 12 Health L.J. 201; and K. Wilson *et al.*, "Addressing the Emergence of Pediatric Vaccination Concerns: Recommendations from a Canadian Policy Analysis" (2006) 97:2 Ca-

immunization plays in protecting the health of the public, and evidence that confidence in immunization is waning, a nuanced, multi-factorial approach will likely be necessary to address the emerging challenges.

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LE MINEUR ET LES SOINS MÉDICAUX, *A.C. C. MANITOBA* : DE L'AUTONOMIE AU MEILLEUR INTÉRÊT, UNE LIMITE BIEN FLOUE

Robert P. Kouri[*]

Par sa décision majoritaire confirmant le droit d'administrer des transfusions sanguines à une jeune Témoin de Jéhovah âgée de 14 ans et 10 mois, nonobstant son refus, la Cour suprême du Canada, dans A.C. c. Manitoba (Directeur des services à l'enfant et à la famille), a affirmé la validité constitutionnelle de la Loi sur les services à l'enfant et à la famille du Manitoba, qui détermine la capacité du mineur à consentir aux soins médicaux sur la base de l'âge et de la maturité. Pourvu que le standard du meilleur intérêt de l'enfant soit retenu, la Cour décide que les droits du mineur à la liberté et à la sécurité, à la liberté de religion et à l'égalité, ne sont pas enfreints par la législation manitobaine. Les dispositions du Code civil du Québec concernant le consentement aux soins médicaux administrés aux mineurs énoncent également la capacité du mineur sur la base de l'âge. Ce commentaire examine la pertinence de l'analyse de la Cour suprême en droit québécois.

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INTRODUCTION

La notion juridique de «minorité» englobe l'être humain de la naissance jusqu'à l'âge de la majorité. La portée de cette notion évolutive varie non seulement en fonction de l'âge, mais également en fonction du genre d'acte que l'on désire poser et de la maturité du mineur. La minorité est normalement une lente progression vers la pleine capacité[1], et donc, la pleine autonomie. Durant cette période, le droit doit offrir au mineur une protection adéquate tout en s'assurant du respect de ses droits fondamentaux.

Le consentement aux soins médicaux illustre parfaitement l'un des domaines où un conflit peut naître entre la volonté de protéger le mineur d'une mauvaise décision qu'il pourrait prendre et le souci de ne pas le brimer dans l'exercice de son autonomie décisionnelle. Dans la cause *A.C. c. Manitoba (Directeur des services à l'enfant et à la famille)*[2], la Cour suprême du Canada a été appelée à statuer sur un tel conflit. Notre intention est de démontrer la pertinence de cette décision en droit québécois, notamment en ce qui concerne la constitutionnalité de certaines dispositions du *Code civil du Québec* qui fixent de façon arbitraire l'âge de la capacité de consentir aux soins[3].

Par son jugement rendu le 26 juin 2009 dans l'affaire *A.C.*[4], la plus haute instance du pays a conclu que la *Loi sur les services à l'enfant et à la famille*[5] est constitutionnelle. Elle a rejeté le pourvoi contre l'arrêt de la Cour d'appel du Manitoba[6], pourvoi qui confirmait l'ordonnance du juge de première instance. Cette ordonnance autorisait l'administration de soins médicaux à une adolescente âgée de quatorze ans et dix mois, nonobstant son refus. Le débat dans cette cause portait essentiellement sur l'application de l'article 25, paragraphes (8) et (9), de la *LSEF*, qui se lisent comme suit :

> 25(8) Sous réserve du paragraphe (9), la Cour peut, à la fin de l'audience, autoriser les examens médicaux, les traitements médicaux ou les traitements dentaires qu'elle juge être dans l'intérêt de l'enfant.
>
> 25(9) La Cour ne peut rendre l'ordonnance prévue au paragraphe (8) sans le consentement de l'enfant qui a au moins 16 ans, sauf si elle est convaincue qu'il ne peut :
>
>> (a) comprendre les renseignements qui lui permettraient d'accorder ou refuser son consentement à l'examen médical, au traitement médical ou au traitement dentaire ;
>>
>> (b) évaluer les conséquences normalement prévisibles qu'entraînerait son consentement ou son refus de consentement à l'examen médical, au traitement médical ou au traitement dentaire.

La fréquence de ce genre de litige devant les tribunaux de plusieurs juridictions n'est pas surprenante[7]. Le refus de traitement est un sujet qui touche non seulement le droit fondamental

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[1] Québec, Ministère de la Justice, *Commentaires du ministre de la justice*, t. 1, Québec, Publications du Québec, 1993 à la p. 110.

[2] *A.C. c. Manitoba (Directeur des services à l'enfant et à la famille)*, 2009 CSC 30, [2009] 2 R.C.S. 181 [*A.C.*], confirmant *Manitoba (Director of Child and Family Services) v. A.C.*, 2007 MBCA 9, 212 Man. R. (2e) 163 [*A.C. MBCA*].

[3] Édith Deleury et Dominique Goubau, *Le droit des personnes physiques*, 4e éd., Cowansville (Qc), Yvon Blais, 2008 à la p. 411, n 474. Pour une description des origines législatives de la détermination de majorité spéciale en matière médicale, voir Robert P. Kouri et Suzanne Philips-Nootens, *L'intégrité de la personne et le consentement aux soins*, 2e éd., Cowansville, Yvon Blais, 2005 aux para. 435-38. Voir également Paul-André Crépeau, «Le consentement du mineur en matière de soins et traitements médicaux ou chirurgicaux selon le droit civil canadien» (1974) 52 R. du B. can. 247 à la p. 250.

[4] *Supra* note 2.

[5] L.M. 1985-86, c. 8, C.P.L.M. c. C80 [*LSEF*].

[6] *A.C. MBCA*, *supra* note 2.

[7] Aux États-Unis, voir par ex. *Novak v. Cobb County-Kennestone Hospital Authority*, 849 F. Supp 1559 (ND. Ga. 1994) (enfant de 16 ans, victime d'un accident de circulation qui refuse des transfusions sanguines) ; *In the matter of Rena*, 705 N.E. 2d 1155 (Mass. App. Ct. 1999) (refus de transfusions sanguines par une per-

à l'autonomie mais aussi, dans plusieurs cas, la liberté de croyance et de religion. Mais devant l'autonomie de plus en plus grande accordée aux mineurs par la société, il devient sans doute périlleux de voir comme immuables des dispositions légales régissant leurs droits et, surtout, restreignant leur liberté d'agir. Comme la législation du Manitoba, le *Code civil du Québec*, à plusieurs endroits, délimite ou élargit parfois la capacité du mineur en ayant recours au critère de l'âge[8]. Ceci est d'autant plus évident en ce qui concerne le consentement aux soins requis par l'état de santé. D'après l'article 14 C.c.Q. :

> Le consentement aux soins requis par l'état de santé du mineur est donné par le titulaire de l'autorité parentale ou par le tuteur.
>
> Le mineur de quatorze ans et plus peut, néanmoins, consentir seul à ces soins. […]

Et selon l'article 16 C.c.Q. :

> L'autorisation du tribunal est nécessaire en cas d'empêchement ou de refus injustifié de celui qui peut consentir à des soins requis par l'état de santé d'un mineur […].
>
> Elle est, enfin, nécessaire pour soumettre un mineur âgé de quatorze ans et plus à des soins qu'il refuse, à moins qu'il n'y ait urgence et que sa vie ne soit en danger ou son intégrité menacée, auquel cas le consentement du titulaire de l'autorité de l'autorité parentale ou du tuteur suffit.

N'ayant jamais subi de test constitutionnel en tant que tel, l'approche du *Code civil* présente pourtant quelques ressemblances avec la loi manitobaine et la pertinence de l'arrêt de la Cour suprême en droit québécois semble, à première vue, évidente. Nous nous demandons donc si ces dispositions du *Code civil*, portées devant la Cour suprême, seraient jugées valables à la lumière de certains droits fondamentaux consacrés par la *Charte canadienne des droits et libertés*[9], tels la liberté de conscience et de religion[10], le droit à la liberté et à la sécurité de la personne[11], ainsi que le droit à l'égalité[12]. Le juriste québécois ne peut pas se permettre d'être indifférent au sort de la loi manitobaine.

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sonne de 17 ans dont la rate s'est rupturée lors d'un accident de planche à neige) ; *In the Matter of Long Island Jewish Medical Center*, 557 N.Y.S. 2d 239 (Sup. Ct. 1990) (mineur de 17 ans dont l'état exige la chimiothérapie ainsi que des transfusions sanguines, qui refuse les transfusions à cause de ses croyances religieuses). En Angleterre, voir par ex. *In re R (A Minor) (Wardship: Consent to Treatment)*, [1991] 4 All E.R. 177, [1992] Fam. 11 (C.A.) (enfant de 15 ans qui est suicidaire et violente et qui, lors d'une période de lucidité, annonce que désormais, elle refusera de prendre ses médicaments psychotropes) ; *Re W (a minor) (medical treatment)*, [1992] 4 All E.R. 627 (C.A.) [*Re W*] (enfant anorexique âgée de 16 ans et qui refuse des soins) ; *Re S (A Minor) (Refusal of Medical Treatment)*, [1995] 1 F.C.R. 604 (Fam. Div.) (enfant âgée de 15½ souffrant de thalassémie majeure et qui refuse des transfusions sanguines). Au Canada, en plus des jugements mentionnés tout au long de ce commentaire, voir aussi *Re Dueck* (1999), 171 D.L.R. (4^{e}) 761, (*sub nom. Re D.(T.T.)*) [1999] 6 W.W.R. 327 (Sask. Q.B.).

[8] Voir par ex. l'art. 156 C.c.Q. reconnaissant la pleine capacité au mineur pour les actes relatifs à son emploi, à l'exercice de son art ou à sa profession ; l'art. 373(1) C.c.Q. concernant le mariage d'enfants de seize ans ; l'art. 708 C.c.Q. ne réservant le droit de tester qu'aux majeurs, sauf les biens de peu de valeur ; l'art. 1813 C.c.Q. limitant le droit de faire une donation.

[9] *Partie I de la Loi constitutionnelle de 1982*, constituant l'annexe B de la Loi de 1982 sur le Canada (R.-U.), 1982, c. 11 [*Charte*].

[10] *Ibid.*, art. 2 : «Chacun a les libertés fondamentales suivantes : a) liberté de conscience et de religion ; […]».

[11] *Ibid.*, art. 7 : «Chacun a droit à la vie, à la liberté et à la sécurité de sa personne ; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale».

[12] *Ibid.*, art. 15(1) : «La loi ne fait acception de personne et s'applique également à tous, et tous ont droit à la même protection et au même bénéfice de la loi, indépendamment de toute discrimination, notamment des discriminations fondées sur la race, l'origine nationale ou ethnique, la couleur, la religion, le sexe, l'âge ou les déficiences mentales ou physiques».

Nous proposons donc d'examiner le cheminement de la cause *A.C.*[13] jusqu'à la Cour suprême et par la suite d'évaluer les effets potentiels de cette décision, s'il y en a, sur le droit québécois d'autant plus que l'analyse du plus haut tribunal s'est limitée à la *common law*.

I

LE MEILLEUR INTÉRÊT ET L'AUTONOMIE DU MINEUR : NOTIONS ANTINOMIQUES OU COMPLÉMENTAIRES SELON LA COUR SUPRÊME ?

A. Les faits de la cause et les recours successifs

Les faits de la cause sont relativement simples et typiques[14]. Membre des Témoins de Jéhovah, A.C., âgée de quatorze ans, est hospitalisée à cause de saignements du tractus gastro-intestinal inférieur causés par la maladie de Crohn. Informé du fait qu'en conformité avec les préceptes de sa religion, la jeune fille a rédigé une directive médicale préalable refusant des transfusions sanguines, le médecin traitant adresse une demande de consultation au département de psychiatrie afin d'obtenir une évaluation de la capacité de sa patiente de comprendre la notion de mort. Les trois psychiatres ayant examiné la patiente sont d'avis qu'en somme, les croyances religieuses d'A.C. sont sincères, qu'elle ne souffre pas de maladie mentale et qu'elle comprend les conséquences possibles d'un refus de transfusion sanguine.

Pendant quelques jours, on réussit à stabiliser son état, mais à cause d'une recrudescence des saignements, des transfusions sanguines s'avèrent médicalement indiquées. A.C. maintient son refus à ce genre de traitement. À la suite d'un signalement, le Directeur des services à l'enfant et à la famille (ci-après le Directeur), appréhende A.C. en tant qu'enfant ayant besoin de protection[15] et obtient du juge Kaufman, de la Cour du Banc de la Reine, une ordonnance de traitement. Trois unités de sang sont alors administrées à la patiente, améliorant ainsi son état.

Lors de l'audition de la demande du Directeur, le juge Kaufman, bien qu'admettant la capacité de la jeune fille de prendre une décision concernant les soins, prétend qu'il n'y a aucune disposition législative limitant le pouvoir du tribunal d'ordonner des traitements médicaux pour un enfant de moins de seize ans lorsqu'on juge que ces soins sont dans le meilleur intérêt de celui-ci.

La cause est portée devant la Cour d'appel : on plaide qu'on a mal interprété la *LSEF*, et qu'une telle ordonnance ne devrait pas être émise pour un enfant de moins de seize ans à moins, bien entendu, qu'il ne soit dépourvu de capacité décisionnelle. On invoque aussi l'incompatibilité de la *LSEF* avec la *Charte*, plus particulièrement les articles 2(a), 7 et 15(1).

La Cour d'appel rejette le pourvoi[16], affirmant que la *LSEF* a supplanté les principes de *common law* applicables aux «mineurs matures» et que la Cour du Banc de la Reine est habilitée à prendre toute décision concernant les soins destinés aux mineurs de moins de seize ans. Même si la volonté et la capacité du mineur peuvent être pertinentes à toute analyse, le critère déterminant est l'intérêt du mineur[17].

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[13] *Supra* note 2.

[14] La Cour suprême du Canada décrit les faits dans son jugement : voir *A.C.*, *supra* note 2 aux para. 5-23.

[15] Selon l'art. 21(1) *LSEF* :

> Le Directeur, un représentant d'un office ou un agent de la paix qui a des motifs raisonnables et probables de croire qu'un enfant a besoin de protection peut appréhender l'enfant sans mandat et le conduire dans un lieu sûr où il peut être détenu à des fins d'examen et de soins provisoires et être traité selon les dispositions de la présente Partie.

L'exigence d'une ordonnance de la cour résulte des art. 25(2) et 25(3) *LSEF* lorsque l'enfant d'au moins seize ans refuse de recevoir le traitement proposé.

[16] *A.C. MBCA*, *supra* note 2 au para. 116.

[17] *Ibid.* aux para. 49, 50, 57.

S'adressant aux arguments basés sur la *Charte*[18], la juge Steel, au nom de la Cour d'appel, les rejette à tour de rôle. L'article 7 concilie, selon elle, deux intérêts en présence : celui de respecter l'autonomie personnelle des adolescents et celui de protéger la vie et la santé des enfants[19]. Elle affirme également qu'il n'est pas arbitraire de fixer à un «âge charnière»[20] (seize ans) une présomption de capacité à prendre une décision relative aux soins médicaux.

Les mineurs ne sont pas brimés dans leur droit à la liberté de religion car toute violation serait justifiée en vertu de l'article 1 de la *Charte*[21], en ce que la protection de la vie et de la santé des enfants constitue un objectif urgent et réel[22]. La *LSEF* n'est pas non plus discriminatoire en établissant une distinction entre les enfants de seize ans et les moins de seize ans : la législation sous étude n'entraîne pas de marginalisation arbitraire des enfants sur la base de l'âge car cette distinction repose sur la dépendance et la maturité incomplète des enfants en tant que groupe[23].

B. L'opinion majoritaire de la Cour suprême

La majorité de la Cour suprême, devant laquelle sont soulevés à toutes fins pratiques les mêmes arguments que ceux plaidés devant les instances inférieures, maintient la validité de l'ordonnance obtenue par le Directeur.

En rejetant l'appel de la décision de la Cour d'appel, le banc de sept juges n'est pas unanime. Non seulement le juge Binnie est-il dissident, mais la majorité est divisée à quatre juges (les juges LeBel, Deschamps, Charron et Abella), contre deux (les juges McLachlin et Rothstein), sur certains points quant à la justification du jugement confirmatif.

L'opinion de la majorité, rendue par la juge Abella, comme celle de la minorité telle qu'exprimée par la juge en chef McLachlin, affirme que la législation manitobaine ne viole pas les articles 2(a), 7 et 15(1) de la *Charte*[24]. Cependant, ces deux groupes y parviennent par des moyens différents. Au risque d'entreprendre une approche trop réductrice de l'opinion de la majorité, notre analyse soulignera les principes dégagés plutôt que d'insister sur la minutie du jugement.

Selon la juge Abella, la *LSEF* a pour fondement le critère de l'intérêt supérieur de l'enfant[25]. D'ailleurs, il est bien dit à l'article 2(1) :

> Dans toute démarche qui est entreprise en vertu de la présente loi et qui touche aux droits d'un enfant, […] le Directeur [des services à l'enfant et à la famille], les régies, le protecteur des enfants, les offices et les tribunaux doivent adopter l'intérêt supérieur de l'enfant comme critère de décision le plus important[26].

L'article ajoute que parmi les critères pertinents d'appréciation, on doit tenir compte des «[…] besoins intellectuels, affectifs, physiques et éducatifs de l'enfant et les soins et les traitements appropriés afin de répondre à ces besoins» (alinéa b) ; «le stade d'évolution intellectuelle, affective et physique de l'enfant» (alinéa c) ; «les opinions et les préférences de l'enfant, lorsqu'elles peuvent être raisonnablement déterminées» (alinéa f) et «le patrimoine culturel, linguistique, racial et religieux de l'enfant» (alinéa h)[27].

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[18] *Supra* note 9.

[19] *A.C. MBCA*, *supra* note 2 au para. 74.

[20] *Ibid.* au para. 79. Dans son jugement, la juge Steel parle de «*dividing line*».

[21] *Supra* note 9.

[22] *A.C. MBCA*, *supra* note 2 au para. 94.

[23] *Ibid.* au para. 105.

[24] *Supra* note 9.

[25] *A.C.*, *supra* note 2 au para. 32.

[26] *LSEF*, *supra* note 5.

[27] Aucune priorité n'existe entre ces facteurs.

Cet énoncé fondamental est directement en lien avec les articles 25(8) et 25(9) de la *LSEF*, édictant en effet que si l'enfant ayant besoin de protection est âgé de moins de seize ans, le tribunal peut autoriser des soins médicaux lorsqu'ils sont dans son meilleur intérêt. Si l'enfant est âgé de seize ans et plus et refuse le traitement, son refus doit être respecté à condition qu'il comprenne l'information pertinente de la décision à prendre et qu'il soit en mesure d'en évaluer les conséquences normalement prévisibles. Si, par contre, l'enfant n'est pas apte à comprendre ou ne peut évaluer les conséquences normalement prévisibles d'un refus de soins, la cour peut, dans le meilleur intérêt de l'enfant, ordonner le traitement en dépit de ce refus.

Donc, la loi exige qu'on respecte la volonté du mineur de seize ans et plus, en présumant que l'expression de sa volonté éclairée est toujours conforme à son meilleur intérêt, tandis que pour les moins de seize ans, une telle présomption n'existe pas[28]. Il importe d'ajouter que cette loi ne s'applique que lorsque l'enfant mineur est appréhendé par le Directeur des services à l'enfant et à la famille, et que l'enfant ou ses parents refusent un traitement médical essentiel[29].

Toute décision prise dans le meilleur intérêt de l'enfant doit tenir compte de sa maturité à l'égard des décisions médicales à prendre[30]. Ainsi, la notion de «mineur mature», telle que formulée par la Chambre des Lords dans l'affaire *Gillick v. West Norfolk and Wisbech Area Health Authority*[31] et appliquée en *common law* canadienne par l'arrêt *J.S.C. v. Wren*[32], garde sa pertinence en ce qui concerne les pouvoirs décisionnels du mineur en matière de santé. À mesure que la capacité de l'enfant de prendre une décision évolue et qu'il est démontré que le mineur est capable de prendre une décision mûre, réfléchie et indépendante, les tribunaux seront tenus de respecter la volonté de l'adolescent[33]. Nous pouvons, à ce sujet, nous en remettre à l'opinion du juge Lambert qui, dans l'arrêt *Van Mol (Guardian ad litem of) v. Ashmore*[34], remarque la clarté de la common law sur la question. Il nous indique effectivement que la capacité qu'ont les parents de consentir au nom de leur enfant ne coexiste pas avec la capacité qu'a l'enfant de consentir en son nom propre. Dès que l'enfant démontre suffisamment d'intelligence et de compréhension pour consentir, son seul consentement suffit. L'accord ou le refus des parents n'y rajoutent désormais rien[35].

Parmi les critères qu'on pourrait utiliser dans l'évaluation de l'autonomie du mineur à prendre une décision, la juge Abella mentionne à titre indicatif :

- Quels sont la nature, le but et l'utilité du traitement médical recommandé? Quels en sont les risques et les bénéfices?
- L'adolescent a-t-il démontré avoir la capacité intellectuelle et le discernement requis pour comprendre les renseignements qui lui permettraient de prendre la décision et d'en évaluer les conséquences possibles?
- Y a-t-il une raison de croire que l'opinion de l'adolescent est bien arrêtée et qu'elle reflète véritablement ses valeurs et croyances profondes?

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[28] *A.C.*, *supra* note 2 au para. 24 :

> Le paragraphe 25(9) présume que l'intérêt supérieur de l'enfant qui a au moins 16 ans sera le mieux servi si ses opinions jouent un rôle décisif dans la décision, à moins qu'il ne soit établi que l'enfant n'a pas la maturité requise pour comprendre la décision et évaluer ses conséquences. Il n'existe pas une telle présomption pour les moins de 16 ans.

[29] *Ibid.* aux para. 2, 86.

[30] *Ibid.* au para. 3.

[31] [1985] 3 All E.R. 402 (H.L.) [*Gillick*].

[32] (1986), 76 A.R. 115 (C.A.) (une jeune fille de 16 ans tombe enceinte et quitte son milieu familial afin de se procurer un avortement. On a décidé qu'elle avait l'intelligence et la compréhension suffisante pour prendre sa propre décision.).

[33] *Supra* note 2 au para. 92.

[34] 1999 BCCA 6, 168 D.L.R. (4^{e}) 637, autorisation de pourvoi à la C.S.C. refusée, [1999] S.C.C.A. n° 117.

[35] *Ibid.* au para 89.

- Quel impact pourraient avoir le style de vie de l'adolescent, ses relations avec sa famille et ses affiliations sociales sur sa capacité d'exercer tout seul son jugement?
- L'adolescent a-t-il des troubles émotionnels ou psychiatriques?
- L'état ou la maladie de l'adolescent ont-ils des incidences sur sa capacité de décider?
- Y a-t-il des renseignements pertinents fournis par des adultes qui connaissent l'adolescent, par exemple des enseignants ou des médecins?[36]

Par conséquent, l'évaluation de la maturité, de l'indépendance et de la capacité de prendre une décision, éléments inhérents au respect du meilleur intérêt du mineur, ne doit pas se limiter aux adolescents âgés de seize ans et plus. Les tribunaux seront alors portés à remplacer la notion de bien-être de l'enfant par celle de l'autonomie en fonction du développement de la capacité de l'adolescent de prendre une décision éclairée[37].

Il en demeure que si la décision du mineur semble compromettre sérieusement sa vie ou sa santé, les tribunaux seront plus rigoureux dans leur évaluation de sa maturité[38]. S'appuyant sur la jurisprudence anglaise, la juge Abella souligne que le tribunal garde toujours le droit d'exercer sa compétence *parens patriae* afin de passer outre les volontés de l'enfant dans les situations où le traitement médical pourrait sauver la vie du mineur[39]. Toutefois, si l'enfant n'a aucune chance de survie, le tribunal choisira plutôt de respecter le choix du mineur. En effet, dans plusieurs décisions de *common law* canadienne, où on a permis aux jeunes Témoins de Jéhovah de refuser des transfusions sanguines, la preuve indiquait dans chaque cas qu'il y avait très peu de chance de survie des patients en question[40].

Compte tenu de ces considérations, la loi manitobaine serait-elle pour autant inconstitutionnelle, comme le prétend la demanderesse A.C. ? Commençant par l'analyse des éléments concernant la liberté et la sécurité de la personne selon l'article 7 de la *Charte*, la juge Abella admet que l'incapacité d'un adolescent de décider de son propre traitement médical constitue une violation de la liberté et la sécurité de l'individu[41]. Cependant, cela est conforme aux principes de justice fondamentale car le but de la *LSEF* est de protéger les enfants[42]. Par contre, en reconnaissant aux mineurs une plus grande autonomie décisionnelle en fonction de leur maturité, un équilibre entre ces deux considérations est maintenu et les dispositions de la loi ne sont pas arbitraires[43].

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[36] *A.C.*, *supra* note 2 au para 96.

[37] *Ibid.* au para. 87.

[38] *Ibid.* au para. 86.

[39] *Ibid.* au para. 56. À cet égard, la jurisprudence anglaise affirme que même la décision d'un enfant «*Gillick competent*» peut être mise de côté par le tribunal lorsque c'est dans son intérêt, voir *Re W*, *supra* note 7 à la p. 643 où le juge Balcombe affirme :

> Nevertheless, if the court's powers are to be meaningful, there must come a point at which the court, while not disregarding the child's wishes, can override them in the child's own best interests, objectively considered. Clearly, such a point will have come if the child is seeking to refuse treatment in circumstances which will in all probability lead to the death of the child or to severe permanent injury.

[40] *Re A.Y* (1993), 111 Nfld. & P.E.I.R. 93 (Unified Fam. Ct.), (enfant de 15 ans avec des chances de rémission entre de 10 ou 20 % et 40 %) ; *Regional 2 Hospital Corp. v. Walker* (1994), 150 N.B.R. (2e) 366, 116 D.L.R. (4e) 477 (C.A.) ; *Re L.D.K.* ; *Children's Aid Society of Metropolitan Toronto v. K. and K.* (1985), 48 R.F.L. (2e) 164 (C.P. Div. Fam. Ont.), jugements que nous avons commentés dans notre ouvrage, Robert P. Kouri et Suzanne Philips-Nootens, *L'intégrité de la personne et le consentement aux soins*, 2e éd., Cowansville, Yvon Blais, 2005 aux pp. 453-455.

[41] *A.C.*, *supra* note 2 au para. 102.

[42] *Ibid.* au para. 104.

[43] *Ibid.* au para. 108.

L'argument de la discrimination sur la base de l'âge est également rejeté car la Cour suprême a déjà, à plusieurs reprises, maintenu de telles distinctions[44].Quoiqu'elle soit arbitraire, une démarcation fondée sur l'âge est malgré tout valable si elle sert une fin législative. En permettant aux mineurs, peu importe leur stade de développement, d'apporter une preuve de maturité à l'égard d'un traitement, cette capacité de choisir est déterminée en fonction de la capacité décisionnelle même et non de l'âge.

Enfin, la Cour rejette la prétention que la loi est en violation de la liberté de religion protégée par l'article 2(a) de la *Charte*. Il est en effet bien dit dans la *LSEF* à l'article 2(1) qu'en évaluant le meilleur intérêt du mineur, on doit tenir compte de son «patrimoine religieux»[45]. En accordant de plus en plus d'importance aux croyances religieuses d'un mineur en fonction de sa maturité croissante, la liberté de religion est alors respectée[46].

À la fin de son jugement fort élaboré, la juge Abella ajoute que, de toute façon, la validité de l'ordonnance du juge Kaufman concernant le traitement est «manifestement théorique» ou en anglais «*clearly moot*»[47]. Mais d'après la Cour suprême dans *Borowski*[48], dans certaines situations exceptionnelles, le tribunal pourrait exercer un pouvoir discrétionnaire et entendre l'affaire si, entre autres, la cause devenue théorique est de nature répétitive et de courte durée et pourrait ainsi échapper à l'examen judiciaire.[49]

Le coût social de l'incertitude du droit est également une justification pour rendre jugement dans une cause devenue théorique[50]. L'administration de transfusions sanguines nonobstant le refus du mineur dans un contexte d'urgence serait une de ces situations où il serait utile de rendre jugement malgré tout.

L'opinion minoritaire rendue par la juge en chef McLachlin est moins nuancée que celle exprimée par la juge Abella. D'entrée de jeu, elle déclare que la *LSEF*

> [...] constitue un code complet en matière de décisions médicales prises par les mineurs appréhendés ou en leur nom. Par conséquent elle supplante les principes de *common law* applicables aux mineurs matures[51].

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[44] *Ibid.* au para. 110.

[45] *Ibid.* au para. 113.

[46] *Ibid.* au para. 113.

[47] *Ibid.* au para. 120.

[48] *Borowski c. Canada (Procureur général)*, [1989] 1 R.C.S. 342, confirmant (1987) 39 D.L.R. (4^{e}) 731, [1987] 4 W.W.R. 385 (Sask. C.A.) et (1983) 4 D.L.R. (4^{e}) 112 (Q.B.) (ci-après cité aux R.C.S.) [*Borowski*].

[49] D'après le juge Sopinka au nom de la Cour, *ibid.* à la p. 353, «[...] si, après l'introduction de l'action ou des procédures, surviennent des événements qui modifient les rapports des parties entre elles de sorte qu'il ne reste plus de litige actuel qui puisse modifier les droits des parties, la cause est considérée comme théorique».

Pour cette raison, la Cour suprême avait rendu jugement dans *Tremblay c. Daigle*, [1989] 2 R.C.S. 530, dans *Office des service à l'enfant et à la famille de Winnipeg (région du Nord-Ouest) c. G. (D.F.)*, [1997] 3 R.C.S. 925, (1997) 152 D.L.R. (4^{e}) 193, ainsi que dans *Nouveau-Brunswick (Ministre de la Santé et des Services communautaires) c. G. (J.)*, [1999] 3 R.C.S. 46 aux para. 42-48.

[50] *Borowski, ibid.* à la p. 361. La présence d'un intérêt national ne suffit pas pour inciter le tribunal à exercer sa discrétion ; il y a aussi le coût social de laisser une question sans réponse, (*ibid.* à la p. 363), telle la nécessité de préciser les droits et obligations des parties lorsque la vie d'un enfant est menacée (*Children's Aid Society of Metropolitain Toronto v. S.H.*, [1996] O.J. (Q.L.) n° 2578 (Ct. J., Gen. Div.) au para. 32, rapportée également *sub. nom. Children's Aid Society of Metropolitain Toronto and T.H. et al.* (1996), 138 D.L.R. (4^{e}) 144).

[51] *A.C., supra* note 2 au para. 126. Voir également *C.U. v. McGonigle*, [2003] A.J. (Q.L.) n° 238, 223 D.L.R. (4^{e}) 662, [2003] 6 W.W.R. 629 (A.B.C.A.) au para. 37, «We agree with the Queen's Bench judge that the [*Child Welfare Act*] provides a complete code respecting this issue. Continued application of the mature minor rule would be inconsistent with the express provisions of that code». La décision de *S.J.B. (Litigation Guardian of) v. B.C. (Director of Child, Family and Community Service)*, [2005] B.C.J. (Q.L.) n° 836, 42 B.C.L.R (4^{e}) 321 (S.C.) au para. 71 [*S.J.B.*] ainsi que *B.H. (Next Friend of) v. Alberta (Director of Child Welfare)*, [2002] A.J. n°,

Par contre, comme la majorité, elle affirme que la loi manitobaine exige que toute décision soit prise dans l'intérêt supérieur du mineur en tenant compte de tous les facteurs pertinents, incluant ceux énumérés à l'article 2(1) de la loi[52]. La gravité des conséquences pour la sécurité du mineur lors d'une prise de décision déterminera le degré de maturité exigé de l'adolescent[53].

En ce qui concerne la constitutionnalité de cette loi, la juge en chef McLachlin soutient, comme la majorité, que la loi est conforme aux exigences de la *Charte*. Certes, l'article 28(8) de la *LSEF* porte atteinte à la liberté du mineur de décider d'un traitement médical[54], mais cette atteinte n'est pas contraire aux principes de justice fondamentale. En ce qui concerne les principes de fond de la justice fondamentale, le but de la législation est, selon elle, de maintenir un équilibre entre l'intérêt de la société à s'assurer que les mineurs recevront les soins exigés par leur état de santé, d'une part, et d'autre part, que leur autonomie décisionnelle sera respectée[55]. Même en différenciant les mineurs de seize ans et plus de ceux de moins de seize ans, cette distinction est conforme à la réalité : la maturité pour prendre une décision d'une telle importance croît avec l'âge car, en plus de l'intelligence de la personne, l'expérience ainsi que son indépendance jouent des rôles importants[56]. Même si la législation reconnaît seulement à l'enfant de seize ans et plus une capacité décisionnelle plus développée, on doit malgré tout tenir compte des préférences du mineur de moins de seize ans en tant qu'élément d'appréciation de son meilleur intérêt[57].

L'aspect procédural du principe de justice fondamentale est également respecté par la *LSEF*, car l'article 2(2) exige que tout enfant de douze ans et plus soit avisé de la nature de l'instance introduite à son sujet. Cet enfant a aussi la possibilité de faire connaître ses opinions et ses préférences. L'article 2(3) reconnaît même au juge le droit de tenir compte de l'opinion de l'enfant de moins de douze ans, si l'enfant est apte à comprendre la nature de l'instance[58].

Quant aux autres objections basées sur la *Charte*, la Cour rejette d'emblée la prétention de la demande que l'adolescente est victime de discrimination selon l'article 15(1) de la *Charte*. En effet, selon la juge en chef, la distinction tracée dans la loi est amélioratrice et non discriminatoire[59]. En cela, autant la juge en chef que la juge Abella rejettent implicitement l'affirmation de Hogg à l'effet que le critère de l'âge n'est utilisé que pour réduire le fardeau administratif qu'impliquerait un test individuel. Les désavantages imposés sur les mineurs en vertu de ce critère pourraient être considérés comme de la discrimination sous l'article 15, puisque ces désavantages sont reliés à un motif de discrimination nommés dans cet article. Hogg ajoute aussitôt qu'il faut cependant espérer que la Cour suprême du Canada confirmer ces désavantages sur la base de la dignité humaine, de la discrimination ou encore sous l'article 1, et ce malgré le fait qu'elle se soit précédemment montrée réticente à admettre que la réduction du fardeau administratif puisse compter comme une justification sous l'article 1[60].

Qui plus est, la Cour écarte l'argument fondé sur la liberté de croyance et de religion car le débat véritable porte sur l'autonomie de la personne en matière de prise de décision, peu im-

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518, [2002] 7 W.W.R. 616 (A.B.Q.B.) au para. 43, confirmant [2002] A.J. (Q.L.) n° 356 (A.B. Prov. Ct.) [*B.H.*], sont au même effet.

[52] *A.C.*, *ibid.* aux para. 132, 133.

[53] *Ibid.* au para. 133.

[54] *Ibid.* au para. 136.

[55] *Ibid.* au para. 141.

[56] *Ibid.* au para. 143.

[57] *Ibid.* au para. 147.

[58] *Ibid.* au para. 148.

[59] *Ibid.* au para. 152. Le texte français du jugement dit que «[...] la distinction établie par la loi [...] apporte une amélioration et non une distinction injuste».

[60] Peter W. Hogg, *Constitutional Law in Canada*, 5e éd. supplémentaire, Toronto, Thomson Carswell, 2007, vol. 2 à la p. 668 (notre traduction).

porte que cette décision soit fondée sur une conviction religieuse ou sur une simple croyance personnelle[61].

C. L'opinion du juge dissident

La dissidence vigoureuse du juge Binnie s'appuie sur la notion que la *LSEF* va à l'encontre de plusieurs dispositions de la *Charte*. Partant du principe que le concept de 'mineur mature' est admis en *common law*, il prétend que

> [...] l'article 25 *LSEF* est inconstitutionnelle parce qu'il empêche une personne de moins de seize ans d'établir qu'elle comprend sa maladie et les conséquences de son refus de traitement et qu'elle devrait donc avoir le droit de refuser le traitement même si le juge des requêtes estime que ce refus n'est pas dans son intérêt, comme c'est actuellement le cas avec le 'mineur mature' de 16 ou 17 ans[62].

Il reproche à la majorité de ne pas donner plein effet à toute décision prise par le mineur ayant la maturité, l'intelligence et la capacité de comprendre les enjeux entourant une décision d'accepter ou de refuser le traitement. En fin de compte, selon la majorité, c'est le tribunal qui décidera en fonction du meilleur intérêt du mineur[63], le privant ainsi de son droit à l'autonomie. D'après le juge Binnie, cette présomption irréfutable d'incapacité du jeune de moins de seize ans viole à la fois les articles 2(a), 7 et 15(1) de la *Charte*.

La liberté de conscience et de religion protège à la fois les pratiques religieuses et les croyances[64]. La non-reconnaissance du droit de refuser des transfusions sanguines est donc une atteinte à la conscience religieuse de la personne[65].

Les droits à la liberté et à la sécurité de la personne sont également atteints par la *LSEF* car d'une part, la notion de liberté comprend le droit de ne pas être assujetti à un traitement médical forcé[66], et d'autre part, la sécurité de la personne vise la protection contre toute atteinte grave à l'intégrité physique, psychologique ou émotionnelle[67].

Ces atteintes ne seraient pas en conformité avec les principes de justice fondamentale. Sur la question de fond, le juge Binnie est d'opinion que «[...] la présomption irréfutable prive [...] les 'mineurs matures' de leur autonomie sans objectif étatique valable», car le but de la loi est de protéger les mineurs n'ayant pas la capacité de voir à leurs propres intérêts en matière de consentement aux soins[68]. Et en ce qui concerne l'équité procédurale, l'existence de la présomption irréfragable d'incapacité, même lorsque les circonstances permettent qu'une preuve de capacité du mineur soit établie, est foncièrement injuste[69].

À l'égard du droit à l'égalité, la discrimination inhérente à la *LSEF* résulte de la présomption irréfragable que les «mineurs matures» de moins de seize ans doivent être traités différemment de ceux de seize ans et plus, car il y a en faveur de ces derniers une présomption simple de capacité, permettant toutefois une preuve contraire[70].

Enfin, le juge Binnie conclut que la justification de l'article 1 de la *Charte* ne peut valider ces atteintes aux droits des mineurs de moins de seize ans, la législation sous étude étant arbitraire,

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[61] *A.C.*, *supra* note 2 au para. 155. Il est intéressant de voir que le juge Kent de la Cour du banc de la reine, dans *B.H.*, *supra* note 51 au para. 48, se sert de ce texte de Hogg pour appuyer son point de vue que l'art. 1 de la *Charte* s'applique.

[62] *A.C.*, *ibid.* au para. 177.

[63] *Ibid.* au para. 202.

[64] *Ibid.* au para. 214.

[65] *Ibid.* au para. 215.

[66] *Ibid.* au para. 217.

[67] *Ibid.* au para. 220.

[68] *Ibid.* aux para. 222, 223.

[69] *Ibid.* au para. 225.

[70] *Ibid.* au para. 227.

injuste ou irrationnelle à la lumière de son objectif de les protéger[71]. À cause de la présomption absolue d'incapacité, on prive les mineurs de moins de seize ans de la possibilité de prouver leur capacité, violant ainsi les droits de ceux n'ayant aucunement besoin de cette protection grâce à leur niveau d'épanouissement. Il y a donc disproportionnalité entre les effets préjudiciables et les effets bénéfiques de cette législation[72].

À la lecture de ces opinions parfois hétérogènes, que peut-on inférer de ce jugement ? En premier lieu, la plupart des membres de la Cour affirment que le principe du «mineur mature» existe en *common law* canadienne en dépit de l'existence d'une législation comme la *LSEF* (selon les juges Abella, LeBel, Deschamps, Charron et Binnie). Deuxièmement, la majorité est d'opinion qu'une distinction basée sur l'âge du mineur est conforme à la réalité entourant le développement des jeunes. Le point de démarcation entre ceux âgés de seize ans et les mineurs de moins de seize ans est donc rationnellement et juridiquement valable. Troisièmement, toujours selon la majorité, l'opinion du mineur de moins de seize ans doit être prise en compte afin de déterminer ce qui serait dans son meilleur intérêt. Cependant, l'opinion du mineur, bien que très pertinente, ne sera pas décisive. On se servira d'un «critère variable en matière d'autonomie décisionnelle» ou, en anglais, d'un «*sliding scale of decision-making*»[73] qui permettra la conciliation des impératifs de protection et de respect de l'indépendance du mineur en fonction de sa maturité. Quatrièmement, la majorité du banc est d'avis que, plus la décision à prendre peut comporter des conséquences graves, plus exigeant sera-t-on dans l'évaluation de la capacité du mineur d'exprimer une opinion judicieuse sur ses préférences de traitement[74]. Cinquièmement, le jugement ne fait aucunement allusion au droit québécois en matière de consentement aux soins, sauf pour réaffirmer le droit de refus du majeur apte en s'appuyant sur la décision dans *Nancy B. c. Hôtel-Dieu de Québec*[75] et en faisant allusion à *Hôpital Sainte-Justine c. Stéphanie Giron*[76], où le refus de soins du mineur avait été écarté par la Cour supérieure.

Nous devons maintenant évaluer la pertinence du jugement relativement à *A.C.* dans l'appréciation de la validité constitutionnelle de certaines dispositions du *Code civil du Québec*.

II

A.C. C. MANITOBA : UNE QUESTION DE NON-INGÉRENCE MAIS DE NON-INDIFFÉRENCE POUR LE JURISTE QUÉBÉCOIS ?

Afin de bien situer les retombées de ce jugement en droit québécois, nous devons souligner certains points de comparaison entre la législation manitobaine et le *Code civil du Québec*. À première vue, il y a certes des différences majeures entre ces deux lois : la *LSEF* ne s'applique que lorsque l'enfant mineur est appréhendé à cause d'un besoin de protection[77], tandis que la législation québécoise représente le droit commun en ce qui a trait au consentement du mineur

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[71] *Ibid.* au para. 233.

[72] *Ibid.* au para. 237.

[73] *Ibid.* au para. 115. D'ailleurs, c'est grâce à la reconnaissance par le tribunal que la *LSEF* permet aux adolescents de participer à toute décision concernant leur traitement médical que l'on peut conclure que cette loi n'est ni arbitraire ni discriminatoire (*ibid.* au para 116).

[74] *Ibid.* aux para. 22, 133.

[75] [1992] R.J.Q. 361 (C.S. Qc.).

[76] [2002] R.D.F. 732 (résumé), 2002 CanLII 34269, 2002 Azimut (publié par SOQUIJ) 50128153 (C.S. Qc.).

[77] *LSEF*, art. 21(1). Si l'enfant n'est pas appréhendé à cause d'un besoin de protection, cette loi ne s'applique pas, voir *Re L.D.K.; C.A.S. v. K.* (1985), 48 R.F.L. (2e) 164 (Ont. Prov. Ct. (Fam. Div.)), p. 170. Selon *Saskatchewan (Minister of Social Services) v. P. (F.)* (1990), 69 D.L.R. (4e) 134 (Sask. Prov. Ct.) aux pp. 142-143, si la décision des parents de refuser certains soins pour leur enfant n'est pas déraisonnable compte tenu des circonstances, les tribunaux doivent refuser d'intervenir. Voir également l'opinion de la juge en chef McLachlin, *A.C.*, *supra* note 2 aux para. 128, 129.

aux soins médicaux[78]. D'emblée cette distinction implique que si une législation, dans une juridiction de *common law*, déroge à cette dernière, son interprétation doit être stricte, tandis qu'en matière de droit civil codifié, la loi doit être appliquée de façon généreuse[79]. L'autre différence est plus lourde de conséquence car, au Québec, une certaine autonomie décisionnelle est reconnue à l'enfant apte âgé de quatorze ans et plus[80]. Or sur le plan développemental de l'adolescent, la différence entre l'enfant de quatorze ans et celui de seize ans est énorme, tel qu'en font foi les autorités citées par la juge Abella[81]. Certes, le choix de quatorze ans par le législateur québécois était en quelque sorte arbitraire si l'on se fie aux représentations faites à l'Assemblée nationale lors des débats sur la question[82]. Mais Deleury et Goubau ont raison de signaler que «[...] l'économie du Code civil va plutôt dans le sens d'une intervention de la part des autorités médicales [...]» dans le cas du refus de soins requis par l'état de santé[83]. Sur le plan conceptuel, on ne peut affirmer qu'une différence de deux ans entre les deux législations est à ce point considérable qu'elle rende l'analyse de la Cour suprême non pertinente au droit civil. La *LSEF* et le C.c.Q. poursuivent une finalité identique : que le mineur reçoive les soins exigés par son état de santé.

A. Convergences et divergences entre la loi manitobaine et le *Code civil*

Examinons maintenant les points de convergence entre ces deux législations, en commençant par le principe directeur de chacune d'entre elles : l'intérêt du mineur. La loi manitobaine affirme sans nuance que «[...] l'intérêt supérieur du mineur est le critère de décision le plus important»[84]. Les articles 12 et 33 du C.c.Q. partent du même principe, car on y affirme que «[...] celui qui consent à des soins pour autrui ou qui les refuse est tenu d'agir dans le seul intérêt de cette personne [...]» ou encore, «[...] les décisions concernant l'enfant doivent être prises dans son intérêt et dans le respect de ses droits»[85].

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[78] Il est intéressant de lire le jugement dans *Trudel c. C.D.* (1999), 2002 B.E.—642 (C.Q. jeun.) où une jeune fille de 16 ans, souffrant d'anorexie, ayant fait l'objet d'un signalement en vertu de la *Loi sur la protection de la jeunesse*, L.R.Q. c. P-34.1, refuse de recevoir à l'interne des soins d'ordre psychologique mais accepte tout soin physique qui pourrait lui être prodigué à l'externe. Le juge a décidé que le consentement du titulaire de l'autorité parentale devait suffire et que de toute façon, ce genre de débat devait être porté devant la Cour supérieure.

[79] Selon Paul-André Crépeau, «Une certaine conception de la recodification», dans *Du Code civil du Québec*, Montréal, Thémis, 2005, 23 à la p. 40, «le code civil constitue un ensemble organique, ordonné, structuré, agencé et cohérent des matières substantielles de droit privé [...]». Voir John E.C. Brierley et Roderick A. Macdonald, *Quebec Civil Law—An Introduction to Quebec Private Law*, Toronto, Emond Montgomery Publications Limited, 1993 à la p. 135 et s. Voir également Pierre-André Côté avec la collaboration de Stéphane Beaulac et Mathieu Devinat, *Interprétation des lois*, 4e éd., Montréal, Thémis, 2009, au para. 103, «Droit commun et non droit d'exception, le droit qu'édicte le Code civil est en principe d'interprétation large [...]».

[80] Art. 14 C.c.Q.

[81] *A.C.*, *supra* note 2 aux para. 70 et s.

[82] Kouri et Philips-Nootens, *supra* note 3 au para. 437. Selon Deleury et Goubau, *supra* note 3 au para. 121, «[La] minorité apparaît comme un état évolutif et l'âge de 14 ans constitue en matière de soins un moment charnière. Depuis 1973, la loi reconnaît à l'adolescent une espèce de majorité anticipée mais incomplète lorsqu'il s'agit de sa santé».

[83] Deleury et Goubau, *ibid.* au para. 122.

[84] Art. 2(1) *LSEF*. On ajoute les éléments dont on doit tenir compte en évaluant cet intérêt supérieur (voir *supra* note 2). D'après l'art. en question, on doit déterminer «[...] cet intérêt supérieur eu égard avant tout à la sécurité de l'enfant [...]».

[85] Lors d'une prise de décision pour le mineur, on doit tenir compte des «[...] besoins moraux, intellectuels, affectifs et physiques de l'enfant, son âge, sa santé, son caractère, son milieu familial et les autres aspects de sa situation», art. 33 al. 2 C.c.Q. La *LSEF* ainsi que le C.c.Q., en adoptant le critère de l'intérêt du mineur, sont en conformité avec le principe énoncé dans la *Convention internationale des droits de l'enfant*, AG, NU, rés. 44/25 (1989), art. 3(1) : «Dans toutes les décisions qui concernent les enfants, qu'elles soient le fait des institutions publiques ou privées de protection sociale, des tribunaux, des autorités administratives ou des organismes législatifs, l'intérêt supérieur de l'enfant doit être une considération primordiale». Cependant, dans la cause *A. et B.*, [2007] R.L. 203 (C.S. Qc.), la Cour a autorisé un garçon de 16 ans à donner de la moelle osseuse à son frère

Les deux législations prévoient également que l'enfant a le droit d'être informé des procédures judiciaires le concernant et d'être entendu. L'article 2(2) de la *LSEF* crée un droit en ce sens en faveur de l'enfant âgé de douze ans et plus[86]. De plus, l'article 2(3) permet la consultation de l'enfant de moins de douze ans si la personne chargée de l'instance est convaincue que l'enfant est apte à comprendre la nature des procédures et n'en subira pas de préjudice. Le *Code civil*, par contre, ne fixe aucun âge où l'on doit consulter le mineur, préférant lui donner la possibilité d'être entendu «[...] si son âge et son discernement le permettent»[87].

Cette consultation du mineur n'aboutit pas cependant aux mêmes résultats dans les deux systèmes. Comme nous venons de le signaler plus haut, dans le cas de la *LSEF*, la cour doit respecter le refus de soins du mineur de seize ans et plus s'il est apte à comprendre les renseignements fournis ainsi que les conséquences normalement prévisibles de son refus[88]. Par contre, le *Code civil* exige l'autorisation du tribunal afin de soumettre un enfant de quatorze ans et plus à des soins s'il les refuse[89]. Nonobstant la nécessité de porter alors la cause devant le tribunal et d'entendre le mineur récalcitrant, le tribunal peut, lorsqu'il s'agit de soins exigés par l'état de santé, ordonner le traitement[90].

B. La décision de la Cour suprême et le droit québécois

Ainsi, le juriste québécois ne peut demeurer indifférent à cette décision de la Cour suprême car, nonobstant son mutisme compréhensible à l'égard des dispositions du *Code civil* sur le consentement aux soins, ses effets seront malgré tout ressentis devant nos tribunaux. L'adhésion sans commentaires des deux juges québécois (LeBel et Deschamps) à l'opinion de la juge Abella nous porte à croire que le silence peut parfois être très éloquent.

Éliminons d'emblée certaines notions évoquées par la Cour suprême et qui n'ont aucune pertinence au droit civil québécois. À l'instar du point de vue de la juge en chef McLachlin qui parlait de la *common law*, nous sommes d'avis que la notion de «mineur mature» n'existe pas non plus dans notre droit, d'autant plus que notre système de droit privé est codifié[91]. Aussi, la doctrine de *parens patriae*, selon laquelle le tribunal peut ordonner le traitement du mineur en vertu d'une compétence inhérente ou innée, n'existe pas en tant que telle en droit québécois. À la différence des provinces canadiennes de *common law*, où, selon les *Judicature Acts*[92], on a revê-

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atteint de leucémie non-lymphatique. Dans le jugement, on a reproduit les art. 33 et 34 C.c.Q. mais on n'a jamais précisé comment ce don pouvait être dans l'intérêt du donneur.

[86] *LSEF*, art. 2(2) :

> Un enfant âgé d'au moins 12 ans a droit d'être avisé de la nature des instances introduites à son égard en vertu de la présente loi et des conséquences possibles de celles-ci à son endroit. L'enfant doit avoir la possibilité de faire connaître ses opinions et ses préférences à un juge ou à un conseiller-maître, chargé de rendre une décision dans une instance.

[87] Art. 34 C.c.Q.

[88] *LSEF*, art. 25(9).

[89] Art. 16 al. 2 C.c.Q. Cet article permet aussi qu'en cas d'urgence mettant la vie ou l'intégrité du mineur en danger, le consentement du tuteur ou du titulaire de l'autorité parentale suffirait pour autoriser les soins nonobstant le refus du mineur.

[90] Art. 23 al. 2 C.c.Q. «[Le tribunal] est aussi tenu, sauf impossibilité, de recueillir l'avis de cette personne et, à moins qu'il ne s'agisse de soins requis par son état de santé, de respecter son refus».

[91] *Supra* note 2 au para. 123. On pourrait même faire nôtre sa déclaration que «Ce régime exhaustif supplante les principes de common law existants qui régissent la prise des décisions médicales par des “mineurs matures”». Voir également *M.S. (litigation guardian of) v. Child and Family Services of Western Manitoba*, [2005] M.J. (Q.L.) n° 17, 249 D.L.R. (4^e) 396, 192 Man. R. (2^e) 23 (C.A.), para. 41, 42 ; *B.H.*, *supra* note 51 ; *C.U. c. McGonigle*, *supra* note 51 ; *S.J.B.*, *supra* note 51. Par contre la Cour d'appel du Manitoba n'était pas toujours de cet avis, voir *Child and Family Services of Winnipeg c. L.L. et C.L.*, [1998] 95 Man. R. (2^e) 16, [1994] 6 W.W.R. 457 au para. 48 et *Kennett Estate v. Manitoba (Attorney General)*, [1998] 129 Man. R. (2^e) 244, [1999] 1 W.W.R. 639.

[92] Par ex. l'Ontario, (*Loi sur les tribunaux judiciaires*, L.R.O. 1990, c. C.43, art. 11(2)), le Manitoba, (*Loi sur*

tu les cours supérieures des pouvoirs de la *Court of Chancery* leur permettant d'exercer certaines prérogatives du souverain, comme l'avait déclaré le juge Mignault dans la cause *Valois* c. *De Boucherville*[93], «[la] cour supérieure n'a pas la juridiction des Cours de Chancellerie en Angleterre»[94]. En droit québécois, la démarche consiste à suivre les directives énoncées au *Code civil*, à condition, bien entendu, que ces directives soient conformes à la *Charte canadienne des droits et libertés*[95] et à la *Charte des droits et libertés de la personne*[96]. On ne peut s'appuyer sur la prérogative de *parens patriae* afin de compter sur un pouvoir résiduaire délégué par le souverain aux tribunaux, leur permettant de veiller sur le bien-être des enfants et des inaptes majeurs. D'ailleurs, dans la cause ontarienne *Rutherford v. Ontario (Deputy Registrar General)*[97], on a même décidé que la juridiction *parens patriae* ne pouvait être exercée qu'en l'absence de législation et uniquement afin de combler un vide[98].

Peut-on affirmer que les dispositions pertinentes du C.c.Q. sont respectueuses des droits et libertés des mineurs lorsqu'on les examine à la lumière de l'arrêt *A.C.* ? Certes, l'obligation d'informer et de tenir compte de la volonté du mineur âgé de moins de quatorze ans ou de quatorze ans et plus et apte à comprendre, répond aux exigences des *Chartes*[99]. Soulignons également que l'opinion du mineur deviendrait plus déterminante en fonction du développement de sa capacité d'exercer un jugement mature et indépendant[100], suggérant ainsi qu'une certaine réserve serait judicieuse en évaluant l'opinion de l'enfant âgé de moins de quatorze ans tandis qu'on accorderait plus de poids à l'appréciation du mineur de quatorze ans et plus. Le choix de l'âge de quatorze ans au Québec, par comparaison à l'âge de seize ans prévu par la *LSEF*, ne change rien quant à la détermination que ces lois ne constituent aucunement une discrimination prohibée par l'article 15(1) de la *Charte*. Cependant, il nous semble qu'un plus grand scepticisme serait de mise en évaluant l'enfant de quatorze ans par opposition à la «maturité» ou capacité de son homologue manitobain âgé de seize ans, d'autant plus que les facteurs d'appréciation du «caractère évolutif et contextuel» de la maturité suggérés à titre indicatif par la juge Abella, ris-

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la Cour du Banc de la Reine, L.M. 1988-89, c. 4, C.P.L.M. c. C280, art. 8), le Nouveau-Brunswick, (*Loi sur l'organisation judiciaire*, L.R.N.-B. 1973, c. J-2, art. 9(1)(b)) et l'Alberta, (*Judicature Act*, R.S.A. 2000, c. J-2, art. 4).

[93] [1929] R.C.S. 234 à la p. 242.

[94] Voir Robert P. Kouri, «L'arrêt *Eve* et le droit québécois» (1987) 18 R.G.D. 643 à la p. 649 ; Michel Morin, «La compétence *parens patriae* et le droit privé québécois : un emprunt inutile, un affront à l'histoire» (1990) 50 R. du B. 827.

[95] *Supra* note 9.

[96] L.R.Q. c. C-12.

[97] (2006) 270 D.L.R. (4^{e}) 90, (2006) 81 O.R. (3^{e}) 81, (S.C.) ; voir également *S.J.B. supra* note 51 au para. 70.

[98] *S.J.B. ibid.* au para. 81, «[...] to fill a legislative gap». Voir également *B.D. c. Newfoundland (Director of Child Welfare)*, [1982] 2 R.C.S. 716 à la p. 724, «[...] à cause d'une déficience de la loi». Selon la cause *Beson c. Director of Child Welfare (T.-N.)*, [1982] 2 R.C.S. 716 à la p. 724, on peut exercer la compétence *parens patriae* lorsqu'il y a une «faille» dans la loi. Dans la cause québécoise *Goyette*, (*In re Goyette : Centre des services sociaux de Montréal métropolitain*, [1983] C.S. 429 à la p. 431), le juge affirme que «[...] sans égard à la loi statutaire, cette compétence [de pouvoir ordonner les traitements] existe en vertu de la doctrine du *parens patriae*». Avec égards, nous ne partageons pas ce point de vue.

[99] *A.C.*, *supra* note 2 au para. 21, faisant allusion, bien entendu, à la *Charte* seulement : «À mon avis, pour que l'interprétation de 'l'intérêt' de l'enfant [...] soit conforme à la Constitution, il faut tenir suffisamment compte de la maturité de l'adolescent visé eu égard au traitement médical en cause».

[100] *A.C.*, *supra* note 2 au para. 22. Voir *B.H.*, *supra* note 51 où l'on affirme au para. 36 que «What a mature minor status requires is the intelligence to do the analysis, not that it has been done». Faisant allusion à l'influence de la religion lors d'une prise de décision, la Cour, dans *Protection de la jeunesse—884*, [1998] R.J.Q. 816 (C.S.) (jeune fille de 13 ans et demi qui refuse une intervention en vue de corriger, au moins partiellement, une scoliose menaçant sa fonction respiratoire au point de la rendre un jour grabataire), déclare à la p. 831 que «[L'enfant] est trop convaincue que Dieu la guérira pour convaincre le Tribunal que sa décision est celle d'une personne douée de discernement et de maturité suffisante pour prendre une décision aussi importante pour son avenir. *Sa décision n'est pas libre*». (Les italiques sont du juge).

quent de trouver leur pertinence autant au Québec qu'au Manitoba[101]. La réserve exprimée par la majorité de la Cour suprême demeurera malgré tout le critère prépondérant. Comme l'affirme la juge Abella, «plus la décision est de nature sérieuse et plus elle risque d'avoir une incidence grave sur la vie ou la santé de l'enfant, plus l'examen doit être rigoureux»[102].

D'ailleurs, un aperçu rapide de la jurisprudence canadienne de *common law* et du droit québécois reflète clairement une telle approche, n'admettant le refus de traitement du mineur que dans des cas où l'avenir du mineur est très sombre et où la science médicale ne peut offrir qu'un espoir fort mitigé de rémission ou de guérison[103].

Y a-t-il lieu d'imputer au C.c.Q. une approche semblable à la *LSEF* où la présomption de capacité joue en faveur du mineur de plus de seize ans et la présomption d'incapacité pèse contre l'enfant de moins de seize ans, compte tenu de la différence d'âge déterminant (quatorze ans) retenu par le législateur québécois ? Si l'on considère les antécédents législatifs d'une telle démarcation, nous constatons que l'intention du législateur était de faciliter l'accès des mineurs aux soins exigés par leur état de santé et non de reconnaître à l'adolescent de quatorze ans et plus la capacité d'un majeur apte en en matière de soins[104]. Les articles 16 alinéa 2 et 23 alinéa 2 C.c.Q. semblent en être la preuve. Selon l'article 16 alinéa 2 :

> [L'autorisation du tribunal] est, enfin, nécessaire pour soumettre un mineur âgé de quatorze ans et plus à des soins qu'il refuse, à moins qu'il n'y ait urgence et que sa vie ne soit en danger ou son intégrité menacée, auquel cas le consentement du titulaire de l'autorité parentale ou du tuteur suffit.

Et l'article 23 alinéa 2 C.c.Q. paraît affirmer le principe que les traitements seront ordonnés lorsque des impératifs thérapeutiques l'exigent : «[Le tribunal] est aussi tenu, sauf impossibilité, de recueillir l'avis de cette personne et, à moins qu'il ne s'agisse de soins requis par son état de santé, de respecter son refus».

Une lecture superficielle ou hâtive de l'énoncé du C.c.Q. pourrait porter à croire que la concomitance de ces deux textes rendrait le principe qu'on semble y affirmer constitutionnellement douteux. En effet, dans tous les cas où le mineur de plus de quatorze ans déclinerait des soins exigés par son état de santé, le tribunal n'aurait pas le choix, le traitement serait ordonné[105]. Selon ce point de vue, le résultat serait incontournable : on priverait le mineur d'un droit de refus, ce qui constituerait une violation de son droit à la liberté et à la sécurité de sa personne, ainsi qu'une discrimination prohibée, basée sur l'âge. En toute logique, on pourrait donc croire qu'il y aurait lieu d'apporter une modification à l'article 23 alinéa 2 C.c.Q. afin de se conformer aux principes dégagés par la Cour suprême. Cependant, une lecture plus attentive de l'article 23 alinéa 2 C.c.Q. nous révèle que l'article impose l'obligation de respecter le refus de soins uniquement lorsque ces soins ne sont pas requis par l'état de santé. Une telle obligation n'existe pas

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[101] *A.C.*, *supra* note 2 au para. 96. Ces facteurs sont reproduits ci-dessus au paragraphe 23.

[102] *A.C.*, *supra* note 2 au para. 22. Ce point de vue est conforme à celui exprimé par Joan M. Gilmour, «Children, Adolescents, and Health Care», dans Jocelyn Downie, Timothy Caulfield et Colleen Flood, *Canadian Health Law and Policy,* 2e éd., Toronto, Butterworths, 2002, 205 à la p. 214 :

> More complex decisions or more serious consequences require more advanced abilities to comprehend, assess, evaluate and judge. That is not to say that a mature minor can never reject life-sustaining treatment, but rather, that the minor must have sufficient judgment to do so, and that a conclusion that the minor is decisionally capable of making such a choice should be subject to closer scrutiny.

Voir également la p. 443.

[103] *Supra* note 40.

[104] Voir Kouri et Philips-Nootens, *supra* note 3, aux para. 435-439.

[105] Dans *Trudel c. C.D.*, *supra* note 78, le juge a même affirmé que dans un cas de refus, le consentement des parents suffirait en cas d'urgence en vertu de l'art. 16(2) C.c.Q. Cependant, dans cette cause, le Directeur de protection de la jeunesse avait le temps et l'opportunité de saisir le tribunal d'une demande d'autorisation. Il n'y avait donc pas de véritable urgence au sens de l'art. 16 C.c.Q.

dans le cas de soins exigés par l'état de santé car le libellé du *Code* exige simplement que le tribunal consulte l'individu concerné avant de prendre une décision en faveur ou contre le traitement, toujours à la lumière du critère fondamental, l'intérêt de la personne[106]. Interprétées de cette façon, les dispositions pertinentes du *Code civil* répondent facilement aux critères de constitutionnalité dégagés par l'arrêt *A.C. c. Manitoba*.

CONCLUSION

La création de certaines présomptions de capacité en fonction d'un âge fixe n'est pas contraire à la *Charte*[107] pourvu qu'en matière de soins et si, bien entendu, les circonstances s'y prêtent, l'on consulte le mineur avant de prendre une décision à son égard. De plus, l'importance accordée à l'opinion du mineur est proportionnelle à son âge et à sa maturité ; plus l'enfant est jeune, plus il sera difficile pour lui de faire respecter sa volonté si sa décision va à l'encontre d'un choix jugé opportun par son entourage familial et médical. Tel qu'annoncé dans le jugement *A.C. c. Manitoba*, les tribunaux seront portés à ordonner les soins dans les cas où la vie ou la santé de l'adolescent serait en danger[108].

Les termes du *Code civil*, comme la *LSEF*, recèlent une présomption latente mais indubitable. Arrimées à la notion du meilleur intérêt, ces deux législations présument que l'acquiescement du mineur aux soins jugés utiles ou nécessaires par ses proches et par les professionnels de la santé serait un consentement mûr et réfléchi. L'approbation d'une telle décision ne ferait pas de doute car il serait normal de prétendre que le mineur a fait preuve de maturité en suivant les conseils de sa famille. Par contre, s'il y avait refus de sa part en dépit de l'insistance de son entourage, l'évaluation de sa capacité serait sans doute très rigoureuse. Dans ce cas, une présomption inexprimée jouerait contre l'adolescent car intuitivement, le fait de refuser des soins exigés par son état de santé serait indicatif d'un manque de compréhension, de sagesse et de maturité[109]. Cette réalité nous laisse songeur car en toute logique, y a-t-il véritablement une différence entre la capacité de consentir et la capacité de refuser les soins[110] ?

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[106] Art. 12 et 33 C.c.Q. D'ailleurs la jurisprudence québécoise semble s'être conformée à ce principe, voir par ex. *Protection de la jeunesse—884*, *supra* note 100 à la p. 831 (autorisant l'opération, le juge affirme qu'en plus de l'intérêt de la patiente, il est aussi dans l'intérêt de la société de préserver ses ressources humaines.) Voir également *Protection de la jeunesse—599*, [1993] R.J.Q. 611 (C.Q.) (adolescente de 17 ans qui a déjà tenté le suicide et qui refuse de prendre sa médication).

[107] Art. 15(1). D'ailleurs, selon P. Hogg, *supra* note 60 aux pp. 55-66, on doit reconnaître que

> [...] our laws are replete with provisions in which age is employed as the qualification for pursuits that require skill or judgment. Consider the laws regulating voting, driving, drinking, marrying, contracting, will-making, leaving school, being employed etc. In regulating these matters, all jurisdictions impose disabilities on young people, employing age as a proxy for ability.

Selon Jean-Pierre Gridel dans «L'âge et la capacité civile» (1998) Recueil Dalloz chronique 90, « L'âge peut être compris sous le seul aspect d'un chiffre. Mais il peut l'être aussi sous celui d'un stade atteint de l'évolution physique, physiologique, mentale de la personne».

[108] Dans *Hôpital de Montréal pour enfants c. D.J. et C.J.G.*, 2001 J.E. 1363, Azimut (publié par SOQUIJ) 50086955 aux para. 3-4, on affirme qu'il n'est même pas nécessaire que la vie de l'enfant soit en danger ou que les soins autorisés le soient *in extremis*.

[109] Nous constatons que lorsque le refus de soins est inspiré par les croyances religieuses du mineur, les tribunaux québécois semblent faire preuve de scepticisme, préférant réserver aux adultes capables le statut de martyr au nom de la religion. Voir par ex. *Hôpital Ste-Justine* c. *Giron*, *supra* note 76 au para. 32,

> Ce n'est pas à un tribunal d'émettre une opinion qu'il est pour ou contre une telle croyance. *What people believe as [a] matter of religious conviction is none of this Court's business. That is my belief*, mais le problème n'est pas là. Quelqu'un devra décider maintenant si cette jeune fille [de 15 ans] est gouvernée, contrôlée par des exigences religieuses ou selon la preuve par une urgente nécessité médicale qui a pour objectif la survie de [l'adolescente].

Voir aussi *M.-W. (J.) c. C.-W.(S.)*, [1996] R.J.Q. 229 (C.A.) à la p. 235, où le juge Baudouin énonce en *obiter*, qu'un «mineur de moins de 14 ans ou la personne inapte appartenant à la même religion et qui n'ont pas [...] conscience [que leur état nécessite des soins], peuvent être traités». En Australie, dans *Re E (A Minor) (Ward-*

La marge de discrétion et la lourde responsabilité reconnues aux juges des faits dans ce genre de cas nous incitent à croire que la magistrature aurait tendance à ordonner le traitement nonobstant le refus du mineur, sauf circonstances très exceptionnelles. Il nous paraît peu probable que lorsque la science médicale propose un traitement présentant une chance réelle de rémission, de guérison ou de soulagement ou encore dispose d'un traitement relativement simple et peu risqué permettant d'éviter une conséquence fâcheuse, par exemple sauver une vie par une simple transfusion sanguine, le tribunal soit enclin à approuver le refus du mineur.

À l'exception de quelques observations que nous avons soulevées dans ce commentaire, nous sommes d'opinion que le C.c.Q. n'est aucunement susceptible d'être ébranlé par la décision de la Cour suprême dans *A.C. c. Manitoba*.

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ship: Medical Treatment), [1992] 2 F.C.R. 219 (Fam. Div.) à la p. 227, le juge Ward affirme : «There is compelling and overwhelming force in the submission of the Official Solicitor that this court, exercising its prerogative of protection, should be very slow to allow an infant to martyr himself». Cette cause portait sur le refus de transfusions sanguines pour des motifs religieux par un garçon leucémique âgé de 15 ans.

[110] Voir *Re W*, *supra* note 7 à la p. 643 (l'opinion du juge Balcombe).

BODY BLOW: MATURE MINORS AND THE SUPREME COURT OF CANADA'S DECISION IN *A.C. V. MANITOBA*

Shawn H.E. Harmon[*]

Autonomy, appropriately defined as the preservation, if not the creation, of space—physical and intellectual—to exercise one's own judgment, is the mantra of the modern era, and the foundation of many legal rights and doctrines, particularly in the medical law context. Though it is persistently extended, particularly in the West, we recognize that it is not the only value that moves us, and this fact causes tensions and poses challenges, as amply demonstrated by the June 26, 2009 decision of the Supreme Court of Canada in A.C. v. Manitoba (Director of Child & Family Services), a case in which a mature minor was forced to receive medical treatment to which neither she nor her parents were willing to consent. This paper considers the Court's decision in this case with a view to exploring in detail its treatment of autonomy and that value's derivative rights, as well as its engagement with other values, critiquing the case and the trend that it (and other Jehovah's Witness cases) signals.

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INTRODUCTION

Autonomy, variously described as "liberty", "freedom", and "the protection of personal integrity",[1] is the mantra of the modern era, and the foundation of many legal instruments, doctrines, and rights, both international and domestic. However, though we are absolutely wedded to it—particularly in the West where it has a strong legal voice[2]—and though it is persistently extended, most of us recognize that it is not, nor should it be, the only value that moves us; it cannot be absolute. And this recognition causes tensions and poses challenges, as amply demonstrated by the June 26, 2009 decision of the Supreme Court of Canada ("SCC") in *A.C. v. Manitoba (Director of Child & Family Services)* ("*AC*").[3] This case comment considers, first, the primacy of autonomy, and then the equivocations that we have erected around its vindication, doing so within the context of the *AC* case. In short, it considers autonomy against the backdrop of a recent and important medical law decision of the SCC. It then offers some preliminary observations about the position and value of the *AC* case in the autonomy and medical law universes, referencing the *Canadian Charter of Rights and Freedoms* ("*Charter*") in the process.[4]

I

BACKGROUND

AC is about a minor who challenged a court order to treat her medically in the absence of her consent, indeed contrary to her clearly stated desire. The facts, very briefly, are as follows:

- The appellant, A.C., a minor aged fourteen years and ten months, suffered from lower gastrointestinal bleeding when admitted to the hospital.[5] As a Jehovah's Witness, she refused a blood transfusion and informed her physicians of the same, additionally indicating that she had an Advance Directive instructing that she not receive transfusions. Her parents supported her decision.
- The following day, her treating physician requested an assessment to determine A.C.'s capacity to refuse treatment, which included the capacity to understand the consequences of doing so, including the risk of death. The report, completed by three psychiatrists, stated that A.C. was alert, cooperative, bright, well spoken, and occasionally teary, and had no psychiatric illness, concluding that A.C. understood why a transfusion may be recommended as well as the consequences of refusal.
- A few days later, A.C. experienced more internal bleeding. A transfusion was recommended. She refused it. She was apprehended as "a child in need of protection" under section 17 of the Manitoba *Child and Family Services Act* ("*CFSA*").[6] Under subsection 25(8) of that act, a court order was sought authorizing blood transfusions as deemed necessary by the physician; the medical evidence demonstrated that if A.C. did not receive blood, she faced "significant risk" associated with oxygen deprivation.[7]

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[1] Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics,* 4th ed. (Oxford: Oxford University Press, 1994) at 121-127, discusses the notion of autonomy in the medical context.

[2] Again in the medical context, see e.g. R. Gillon, "Ethics Needs Principles—Four Can Encompass the Rest and Respect for Autonomy should be 'First Among Equals'" (2003) 29 Journal of Medical Ethics 307.

[3] *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, 309 D.L.R. (4th) 581 [*AC*].

[4] Part I of the *Constitution Act, 1982*, being schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[5] The Manitoba *Age of Majority Act*, C.C.S.M. c. A7, s. 1(1) defines a "child" as anyone under the age of "majority" (i.e., 18).

[6] S.M. 1985-86, c.8, C.C.S.M. c. C80.

[7] *Supra* note 3 at para. 11, Abella J.

- Without having undertaken an assessment of her maturity, the Provincial Court assumed that A.C. had capacity, but granted the treatment order, stating that a child under sixteen years is squarely within the court's authority to order medical treatment in a child's best interests, and that A.C.'s best interests were served by the proposed intervention. Treatment was subsequently administered and A.C. recovered.
- A.C. and her parents appealed the decision to the Manitoba Court of Appeal, which dismissed the appeal. They then appealed to the SCC, arguing that the *CFSA* violated the *Charter* by infringing section 2(a) (freedom of religion), section 7 (security of the person), and section 15(1) (freedom from discrimination based on age) because it denied her (and others under sixteen) the right to demonstrate capacity and have their treatment wishes respected.

The case before the SCC turned primarily on the interpretation and application of section 25 of the CFSA, which authorizes child protection authorities to impose treatment on minors in the absence of consent.

Ultimately, a medical examination can be authorized by the agency where the consent of a parent or guardian would otherwise be required. Under paragraph 25(1)(c), medical treatment can be authorized if:

> (i) the treatment is recommended by a duly qualified medical practitioner or dentist,
>
> (ii) the consent of a parent or guardian of the child would otherwise be required, and
>
> (iii) no parent or guardian of the child is available to consent to the treatment.

Further paragraphs of section 25 of the *CFSA* clarify the following:

- Where a child is sixteen or over, neither medical examination nor treatment can be authorized without the consent of the child. When a child sixteen or over refuses consent, or when the parents of a child under sixteen refuse consent, the authorities may apply to a court for an order authorizing the treatment.[8]
- The court may, upon completion of a hearing, authorize any medical treatment that it considers to be in the best interests of the child.[9]
- The court shall not make an order with respect to a child sixteen or older without the child's consent unless it finds that the child is unable

  (a) to understand the information that is relevant to making a decision to consent or not consent to the medical treatment; or

  (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent.[10]

II
THE PRIMACY OF AUTONOMY

As a socio-ethical value, autonomy, grounded in the dignity and worth of the human person, might be defined as involving the preservation, if not the specific creation, of space—physical, emotional, and intellectual—to exercise one's own judgment and to vindicate one's own will with respect to matters relating to oneself.[11] As shall be discussed, in Canada, the concept of auton-

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[8] *Supra* note 6, ss. 25(2)(3).

[9] *Ibid.*, s. 25(8).

[10] *Ibid.*, s. 25(9).

[11] See Shawn Harmon, "Regulation of Human Genomics and Genetic Biotechnology: Risks, Values and Analytical Criteria" (2005) InnoGen WP-40, online: Genomics Network <http://www.genomicsnetwork.ac.uk/

omy is implicated in both constitutional law and medical common law, which, together, protect freedoms relating to thought, decision, and action, all of which are constituent elements of autonomy writ large.

With respect to Canadian constitutional law as it is implicated by the *AC* case, sections 2(a) and 7 of the *Charter* state:

> 2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion;
>
> …
>
> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Generally, subsection 2(a) erects a zone of protection from state interference around (1) an individual's personal beliefs about the foundation of "truth" relating to creation, existence, and human nature, or a philosophy of life; (2) the institutions in which individuals participate relating to the same; and (3) the practices individuals undertake as a result of membership in those institutions.[12] The right will be infringed where (1) the claimant sincerely or profoundly holds a belief or practice that has a nexus with religion, and (2) the state action interferes with the claimant's ability to act in accordance with that belief in a manner that is more than trivial or insubstantial.[13] As explicitly noted in *R. v. Big M Drug Mart Ltd.*, the right rests on the values of autonomy and dignity, the objective being to shelter from state interference of a non-trivial nature profoundly personal beliefs that govern one's perception of oneself, humankind, nature and, sometimes, a higher or different order of being, and that therefore govern one's conduct and practices.[14]

Section 7 protects two autonomy-implicating rights: "liberty" and "security of the person".[15] In *Big M Drug Mart*[16] and *R. v. Oakes*,[17] Chief Justice Dickson articulated the concepts that inform the constitutional right of liberty as follows:

- respect for individual conscience and judgment, which lies at the heart of our democratic political tradition;
- respect for the ability of each individual to make free and informed decisions, which is a prerequisite for the legitimacy, acceptability, and efficacy of our system of self-government;

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media/Innogen Working Paper 40.pdf>.

[12] See *R. v. Jones*, [1986] 2 S.C.R. 284, 31 D.L.R. (4th) 569 [*Jones*]; *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, 35 D.L.R. (4th) 1 [*Edwards Books*]; and *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, 310 D.L.R. (4th) 193, 9 Alta. L.R. (5th) 1 [*Hutterian*], for more on freedom of religion. *Hutterian*, citing *Metropolitan Church of Bessarabia and Others v. Moldova*, No. 45701/99, ECHR 2001-XII (ECHR), notes that freedom of religion has both individual and group elements.

[13] *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551, 241 D.L.R. (4th) 1.

[14] [1985] 1 S.C.R. 295 at paras. 94-99, 123, 18 D.L.R. (4th) 321 [*Big M Drug Mart*].

[15] See *Singh v. Minister of Employment and Immigration*, [1985] 1 S.C.R. 177 at 204-08, 17 D.L.R. (4th) 422 [*Singh*] (Wilson J. clarified that s. 7 contained three separate interests that had to be protected); *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, 24 D.L.R. (4th) 536 (reiterated the interests set out by Wilson J. in *Singh*); see also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, 107 D.L.R. (4th) 342 [*Rodriguez*] (Sopinka J. stated that the right to life, grounded on the respect for life value, stood against the others and none could prevail a priori over another). In line with Sopinka J., I would argue that the first interest, "life", is not particularly autonomy-implicating, although the exercise of autonomy certainly depends on the existence of life.

[16] *Supra* note 14 at paras. 94-95.

[17] [1986] 1 S.C.R. 103, at 119, 134.

- respect for human dignity, commitment to social justice and equality, accommodation of plurality and cultural/group identity, and faith in social and political institutions, all of which enhance participation in society.

The SCC has held that liberty is infringed when the state interferes with the following: (1) individual abilities to develop and realize one's potential, plan one's life to suit one's character (being non-conformist, idiosyncratic, or eccentric);[18] (2) individual rights to make fundamental choices such as where one resides;[19] (3) parental rights to raise children in accordance with one's conscientious beliefs;[20] (4) parental decision-making with respect to children's medical care;[21] and (5) access to medical treatment without undue delay.[22]

An individual's right to security of the person has both physical and psychological components: the right is infringed when the state threatens to or actually violates physical integrity through punishment or infliction of suffering; the state also breaches the right when it causes psychological trauma by treating individuals as a means to an end rather than as a valued end in themselves, stigmatizing the individual, delivering stress and anxiety through the imposition of uncertainty, disruption, publicity, expense, and so on.[23] In short, section 7 extends to individuals' security over their physical and mental integrity and the right to maintain and control the same.[24] As such, in *R. v. Morgentaler*,[25] it was held that state interference with bodily integrity and state-imposed psychological stress brought about by use of the criminal law—both stemming from an attempt by the state to control a woman's capacity to reproduce—constitute a breach of the security of the person.

The section 7 rights of liberty and security of the person therefore implicate the value of autonomy in a very deep and direct way. They are directed at providing the individual with the physical and psychological/emotional space and safety to make judgments as to what is best for herself and to exercise her will in conformity therewith. In *Big M Drug Mart*, Chief Justice Dickson held that liberty constitutes allowing individuals room to exercise personal autonomy to live their lives and to make decisions that are of fundamental personal importance.[26] Similarly, in *Morgentaler*, Justice Wilson stated that liberty grants the individual a degree of autonomy in making decisions of fundamental personal importance and pursuing one's own conception of a full and rewarding life.[27]

As indicated above, autonomy is also implicated in the medical common law. Support for the value can be found in practices and doctrines relating to consent to treatment, patients' rights to information, and health data protection, all of which are critically important in the modern clinical and medical research settings.[28] With respect to consent, which is considered one of the

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[18] *Jones*, *supra* note 12 at para. 76.

[19] *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 at paras. 58-72, 152 D.L.R. (4th) 577.

[20] *Jones*, *supra* note 12 at paras. 79-81.

[21] *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at 362-74, 122 D.L.R. (4th) 1.

[22] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791 at paras. 28, 43, 109-125, 254 D.L.R. (4th) 577 [*Chaoulli*].

[23] See *Singh*, *supra* note 15; *Chaoulli*, *ibid.*; *R. v. Therens*, [1985] 1 S.C.R. 613, 18 D.L.R. (4th) 655; *Mills v. The Queen*, [1986] 1 S.C.R. 863, 29 D.L.R. (4th) 161; *R. v. Whyte*, [1988] 2 S.C.R. 3, 51 D.L.R. (4th) 481; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, 177 D.L.R. (4th) 124; and *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307,190 D.L.R. (4th) 513 [*Blencoe*].

[24] See *R. v. Videoflicks Ltd.* (1984), 48 O.R. (2d) 395 (C.A.), 14 D.L.R. (4th) 10.

[25] [1988] 1 S.C.R. 30, at 56, 173, 44 D.L.R. (4th) 385 [*Morgentaler*].

[26] *Supra* note 14 at paras. 94-95.

[27] *Supra* note 25; see also *Blencoe*, *supra* note 23.

[28] See *Morgentaler*, *supra* note 25 (Dickson C.J.C. noted that, at common law, medical procedures carried out on a person without that person's consent constitutes an assault, a position grounded in physical integrity);

most significant vehicles for realizing autonomy and the self-determination that it supports,[29] the following propositions can be distilled from the common law,[30] and were endorsed by Justice Abella in the majority judgment of *AC*:

- There is a rebuttable presumption that adults are competent, and the burden of disproving competence rests on the person challenging it.[31]
- Adults are entitled to sufficient information to enable them to make a decision that is informed, and to direct the course of their own medical treatment through the giving or refusing of informed consent.[32]
- The power to direct one's own medical treatment includes the right to refuse life-saving treatment.[33]
- While physicians cannot normally proceed in the absence of consent, an exception exists where emergency circumstances prevail and the person is not in a position to give or refuse consent, the assumption being that consent is implied or that the physician is entitled to proceed on the basis of necessity.[34]

These rights were traditionally restricted where minors were concerned (and in certain limited public health situations), but those restrictions on autonomy have been eroded.[35] Thus, whereas most minors were long considered a vulnerable class in need of (paternalistic) adult guidance and state protection,[36] the common law has, relatively recently, recognized decisional capacity in minors, extending to them autonomy-based consent as well as refusal powers, even in respect of illnesses and conditions with dire consequences.[37] Hence, it is now accepted that parental authority declines in accordance with the minor's evolution into adulthood, and, provided the minor is capable of understanding the proposed treatment and of expressing her wishes, those wishes must be considered (though may not be determinative). Again, the majority judgment supported these propositions.[38]

Emphasizing the great societal importance attached to individual integrity and liberty, and noting that this importance is reflected in our legal system, Justice Abella stated:

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see also Simon Verdun-Jones & David Weisstub, "Consent to Human Experimentation in Québec: The Application of the Civil Law Principle of Personal Inviolability to Protect Special Populations" (1995) 18 Int'l J.L. & Psychiatry 163. The medical common law has evolved to include more protections, many informed by autonomy as an emerging value. Many of the common law protections (e.g. consent to treatment) originate in the concept of physical inviolability, which is aimed at protecting the physical integrity of the patient.

[29] Verdun-Jones & Weisstub, *ibid.*; Bruce J. Winick, "On Autonomy: Legal and Psychological Perspectives" (1992) 37 Vill. L. Rev. 1705.

[30] See *Rodriguez*, *supra* note 15; *Morgentaler*, *supra* note 25; *Reibl v. Hughes*, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1; *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.), 67 D.L.R. (4th) 321 [*Malette*]; *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), 82 D.L.R. (4th) 298 [*Fleming*].

[31] *Supra* note 3 at para. 40.

[32] *Ibid.*

[33] *Ibid.* at paras. 44-45.

[34] *Ibid.* at para. 42.

[35] *AC*, *supra* note 3 at para. 46, Abella J.

[36] Exceptions here are emancipated minors and mature minors, the latter being a relatively recent conceptualization.

[37] This extension began in the U.K. with *Gillick v. West Norfolk & Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (H.L.), [1985] 3 W.L.R. 830, but quickly found a foothold in Canada in *J.S.C. v. Wren* (1986), 76 AR 115 (C.A.), 35 D.L.R. (4th) 419 and *Van Mol (Guardian Ad Litem of) v. Ashmore* (1999), 168 D.L.R. (4th) 637 (B.C.C.A.), 168 D.L.R. (4th) 637, among other cases.

[38] *AC*, *supra* note 3 at paras. 46-63, Abella J.

> The legal environment for adults making medical treatment decisions is important because it demonstrates the tenacious relevance in our legal system of the principle that competent individuals are—and should be—free to make decisions about their bodily integrity.

She later quoted favourably from *Fleming v. Reid*,[39] wherein it was held that every person's body is inviolate, an idea deeply rooted and tied to consent. Justice Abella further exposed our appetite for autonomy by suggesting that a minor's best interests will, as she gets older and more mature, collapse into her desire and right to exercise autonomy.[40] In short, there comes a time when it is in the child's best interests to exercise autonomy, whatever consequences the exercise of that autonomy might result in; her best interests are *the exercise* of autonomy.

Chief Justice McLachlin, writing for herself and Justice Rothstein, was also autonomy-supportive, but no opinion demonstrated a stronger claim that autonomy occupies the pinnacle of legal value than that of Justice Binnie. In his dissent, after describing forced medical treatment as one of the most egregious violations of a person's integrity, he stated:

> [It] is ... fundamental that every competent individual is entitled to autonomy to choose or not to choose medical treatment except as that autonomy may be limited or prescribed within the framework of the Constitution. The rights under s. 2(a) of the Charter (religious freedom) and s. 7 (liberty and security of the person) are given to everyone, including individuals under 16 years old.[41]

He concluded that the SCC has "long preached the values of individual autonomy," and he characterized this case as a call to live up to the autonomy promise contained in sections 2(a) and 7.[42] Justice Binnie went on to hold that the state's interest in controlling the medical treatment of minors ceases where a minor, though under the age of sixteen, demonstrates maturity and thus has no need for any overriding state control; the legitimate basis of state intervention has, by reason of the finding of maturity, disappeared, and the minor is entitled to live or die by her decision.[43] He noted that, in the present case, three psychiatrists and the judge at first instance accepted that A.C. had capacity.[44] Subsection 25(8) prevented her from making the decision on her own and therefore contravened sections 2(a) and 7 of the *Charter*; it created an irrebuttable presumption of incapacity that was not justified by section 1 of the *Charter*.

The above demonstrates that autonomy is deeply embedded in Canadian society, is legally mandated and constitutionally protected, and has been extended in the health context beyond historical categories to persons we (still) consider incompetent to do many things. The *CFSA* empowers competent minors ages sixteen to eighteen to exercise the same autonomy rights as an adult; minors under sixteen, who have demonstrated their capacity, can express their wishes and have those wishes considered. Ultimately, while Justice Binnie's vision did not carry the day, the *CFSA* dramatically lowers the age at which children can have a hand in decision-making.

III

TENSIONS AND EQUIVOCATIONS AROUND AUTONOMY

However, the *AC* case is not about the unfettered triumph of autonomy. As the case demonstrates, we find ways to circumvent the exercise of autonomy when we consider it just or expedient. Thus even mature minors can have their wishes overridden where the court, in exercising its *parens patriae* jurisdiction or, as here, interpreting statutory provisions, is of the opinion that their best interests are served by another course. Writing for the majority, Justice Abella

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[39] *Supra* note 30.

[40] *AC*, *supra* note 3 at paras. 84-98.

[41] *Ibid.* at para. 192.

[42] *Ibid.* at para. 219.

[43] *Ibid.* at paras. 221-224.

[44] *Ibid.* at para. 225.

took some care in explaining that the requisite maturity comes gradually and unevenly, and is dependent on personal characteristics and context.[45] She explained:

> There is considerable support for the notion that while many adolescents may have the technical ability to make complex decisions, this does not always mean that they will have the necessary maturity and independence of judgment to make truly autonomous choices.[46]

Moreover, maturity is terribly difficult to measure, and where we are not satisfied that it has been demonstrated, having reference to a number of factors, the court should determine the appropriate course with input from the minor. On that issue, Justice Abella concluded:

> With our evolving understanding has come the recognition that the quality of decision-making about a child is enhanced by input from that child. The extent to which that input affects the best interests assessment is as variable as the child's circumstances, but one thing that can be said with certainty is that the input becomes increasingly determinative as the child matures. This is true … when deciding whether to accede to a child's wishes in medical treatment situations.[47]

The consequence of the *CFSA*, as interpreted by Justice Abella, is that if we cannot trust that a minor will exercise true autonomy, we will not permit her to make the decision, and, additionally, we will weigh her input accordingly. In such a case, her best interests must be protected.[48] The assessment of her best interests is structured in the present case by subsection 2(1) of the *CFSA*:

> 2(1) The best interests of the child shall be the paramount consideration … and in determining best interests … all other relevant matters shall be considered, including the following:
>
> (a) the child's opportunity to have a parent-child relationship as a wanted and needed member within a family structure;
>
> (b) the mental, emotional, physical and educational needs of the child and the appropriate care or treatment, or both, to meet such needs;
>
> (c) the child's mental, emotional and physical stage of development;
>
> (d) the child's sense of continuity and need for permanency with the least possible disruption;
>
> (e) the merits and the risks of any plan proposed by the agency that would be caring for the child compared with the merits and the risks of the child returning to or remaining within the family;
>
> (f) the views and preferences of the child where they can reasonably be ascertained;
>
> (g) the effect upon the child of any delay in the final disposition of the proceedings; and
>
> (h) the child's cultural, linguistic, racial and religious heritage.

An integral element of this assessment is the preferences of the minor. In determining the weight that should be given to those preferences, the minor's maturity must be rigorously assessed.[49] In the majority judgment, Justice Abella clarifies that the following factors require consideration:

- What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?

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[45] *Ibid.* at paras. 71-79 (here Abella J. cited a variety of scholarly material).

[46] *Ibid.* at para. 71.

[47] *Ibid.* at para. 92.

[48] Ultimately, as a minor, her objective best interests must be protected, and they are heavily coloured by the respect for life value. Once that minor becomes an adult, her best interests, as far as the state is concerned, are largely synonymous with the exercise of her own judgment, whatever consequence that might have for her life, health, or treatment.

[49] See *AC*, *supra* note 3 at paras. 94-96, Abella J.

- Does the [minor] demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?
- Is there reason to believe that the [minor's] views are stable and a true reflection of his or her core values and beliefs?
- What is the potential impact of the [minor's] lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment?
- Are there any existing emotional or psychiatric vulnerabilities?
- Does the [minor's] illness or condition impact on his or her decision-making ability?
- Is there any relevant information from adults who know the [minor], like teachers or doctors?[50]

These factors reflect a structured attempt to realize another important value, not so much respect for life, but solidarity with others. The above also serves to demonstrate our conviction, alluded to in the *CFSA*'s preamble, that society has a duty to protect minors and to help them flourish to the extent permitted by the operation of other important values and existing socio-economic structures. The consequence for the minor is that she need only be afforded a degree of autonomy, imprecisely commensurate with her maturity, and society is to be afforded the right to paternalistically protect her life and health and vouchsafe her ability to flourish, all to a diminishing extent as she ages.

Such was the conclusion of Justice Abella and Chief Justice McLachlin, both of whom found the *CFSA* constitutionally sound (or saved). Drawing on the common law, Justice Abella stated that the multifactored best interests approach embodied in subsection 25(8) erects a sliding scale of scrutiny whereby the minor's views become increasingly determinative with greater maturity; the more serious the nature of the decision and the more severe its potential health impact, the greater the degree of scrutiny required.[51] Minors under sixteen have the right to demonstrate maturity, and courts making decisions on their behalf must give weight to their opinion commensurate with that maturity. In assessing maturity, the court must take into account the above factors. So construed, the *CFSA* strikes a constitutional balance between an individual's fundamental right to autonomous decision-making and the law's attempts to protect the vulnerable from harm, and it does not violate sections 2(a), 7, or 15 of the *Charter*; it is neither arbitrary, discriminatory, nor contrary to religious freedom.

In a minority opinion concurring in result, Chief Justice McLachlin rejected the common law as irrelevant,[52] and stated that bodily integrity (protected by the security of the person interest under section 7) is not absolute and does not trump all other interests; limits placed on autonomy-grounded section 7 rights that advance a genuine state interest, are acceptable where they are shown to be based on rational grounds.[53] She opined that (1) the statutory scheme successfully balances autonomy with society's interest in ensuring that minors receive necessary care, and (2) using age sixteen to impose the burden of proving maturity is a legitimate response to concerns about coercion and influence (i.e., age is a reasonable proxy for independence and ability to understand and appreciate consequences of the decision and alternatives).[54] As such, section 7 was not violated. With respect to section 15, she noted that the discrimination-founding ground (i.e., age) must create disadvantage by perpetuating prejudice or stereotype.[55] Children

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[50] *Ibid.* at para. 96.

[51] *Ibid.* at paras. 108-116.

[52] *Ibid.* at paras. 123-126.

[53] *Ibid.* at para. 137.

[54] *Ibid.* at paras. 134-149 (McLachlin C.J.C. limited her analysis to s. 7 and its internal limitations, and did not make reference to s. 1 of the *Charter*).

[55] *Ibid.* at para. 150.

are recognized as a highly vulnerable group.[56] Hence, the use of age in the present setting (i.e., the requirement that the judge take into account the treatment preferences of those under sixteen where maturity is demonstrated) is ameliorative, and thus not contrary to section 15.[57] Finally, while the scheme does violate subsection 2(a), it is justifiable under section 1 of the *Charter* because the objective of ensuring the health, safety, and life of vulnerable minors is pressing and substantial, and the means chosen—giving discretion to the court to order treatment after a consideration of all relevant circumstances—is a proportionate limit.[58]

Such was the decision. A.C. received her treatment, her post hoc appeal was dismissed, the statutory scheme was found to be constitutional and the authorities were concomitantly exonerated of any wrongdoing, and A.C. lived to fight another day. The question remains: What is the value of this case, generally, with respect to its implications for autonomy as a value, and with respect to the rights of liberty, security of the person, and freedom of religion, all of which are at least partially grounded on autonomy (and their support of prior consent to medical treatment and the duty to obtain it)?

IV

VALUING THE CASE: AUTONOMY, MATURITY & HONESTY

A. The Case Generally

From a general standpoint, this case is important insofar as the majority judgment summarizes and clarifies the common law of consent to medical treatment for adults and mature minors. Additionally, and equally pragmatically, it reasonably and clearly outlines the proper process, under this particular statutory scheme, for assessing maturity and approaching decisions with respect to minors of different ages. Having said that, an obvious criticism of the case stems from the bewildering conclusion of Chief Justice McLachlin that no reviewable error had been committed by the application judge.[59] While the passing of the medical emergency (and indeed of A.C.'s status as an under-sixteen minor) makes this point less significant, the fact remains that Justice Kaufman, the applications judge, utterly failed to anticipate (and thus comply with) the demands of the *CFSA* as enunciated by the majority. He never subjected the psychiatric report to a searching judicial review, refused to allow A.C. to present evidence at the conference call hearing of her capacity, and erroneously concluded that such evidence from her would be irrelevant because she was under sixteen.[60]

B. The Case and the Autonomy Value

With respect to the autonomy value more specifically, the case is ambivalent. Although autonomy continues to dominate in Western medical practices, and its importance to that setting (and others) is explicitly accepted, the case explicitly recognizes the tensions between our demands for autonomy, on the one hand, and our lingering (if often un-vindicated) sense of responsibility toward others, including minors, on the other hand.[61] This is both important and valuable. Unfortunately, the decision did not actively or intellectually engage with these tensions

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[56] See *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4, [2004] 1 S.C.R. 76, 234 D.L.R. (4th) 257.

[57] See *AC*, *supra* note 3 at para. 152, McLachlin C.J.C.

[58] *Ibid.* at paras. 153-156, McLachlin C.J.C.

[59] *Ibid.* at para. 159; see also paras. 118-121 (Abella J. found the issue of the validity of the treatment order to be moot).

[60] *Ibid.* at paras. 10-12, 118-120, 159, 173.

[61] The two concurring judgments pointed out that minors under 16 are often not fully formed beings to whom we should abdicate all decision-making powers.

in an entirely satisfactory manner, and is therefore perhaps more significant for what it fails to do. Most significantly, again from a value perspective, it fails to:

- offer authoritative definitions of autonomy, solidarity and respect for life as moving social and ethical values;
- explore the interaction of these values with the implicated constitutional rights and therefore the practical demands of these values; or
- undertake a deep interrogation of the appropriate balance between these values in the context of a "best interests of the child" assessment.

While some of these undertakings were not strictly necessary for the disposition of the case, their explicit consideration would certainly have contributed to a richer decision. Moreover, as an undeniably important institution for social and policy development within our constitutional setting, the SCC might be expected to engage with these higher level values, particularly in the medical law setting which is so imbued with concepts of social, ethical, and constitutional significance.

C. The Case and Autonomy-Derivative Rights

The value of the case can be similarly questioned in regards to its engagement with *rights* derivative of autonomy, particularly the fundamental right of freedom of religion and the more mechanistic right of consent in the medical context.

With respect to the exercise of consent in the medical context, there are two points worth mentioning briefly. First, there is the majority and concurring judgments' differential treatment of minors over sixteen and minors under sixteen. One might argue that this differential treatment is curious in the absence of any evidence of a compelling state interest in subjecting the medical treatment of those under sixteen to judicial control irrespective of their capacity to make such decisions themselves. Searching criticism has already been levelled against them for this unsupported differentiation which need not be repeated here.[62]

Second, there is the blunt manner in which the state interjected itself between the minor patient and the exercise of her autonomy through the evidence-light procedure of having her declared "a child in need of protection" under the *CFSA*. Despite A.C.'s apparent competence, and her parents' support of her refusal to consent, the state is statutorily empowered to (and did) intervene, setting in motion a process that removed A.C.'s decisional capacity and vested it in the courts. While rhetorical affinity for autonomy may endure, and may even, to some extent, be reiterated in the statutory scheme, the process itself amply demonstrates the tensions noted above.

With respect to the former and more fundamental right of religious freedom, the case offered little guidance—and less hope—around the vindication of this subsection 2(a) *Charter* right in this particular setting. It is well known that the rejection of blood transfusions by Jehovah's Witnesses is fundamental to their religious convictions. They believe that blood represents life, and they interpret the Bible to mean that respect for the gift of life requires them to abstain from accepting blood—through food, drink, or transfusion—to sustain life, even in times of emergency.[63] Devout Jehovah's Witnesses understand a spiritual life to require that death be

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[62] See *AC*, *supra* note 3 at paras. 206-237, Binnie J., dissenting.

[63] The Watchtower Society maintains that transfusions are synonymous with eating blood, which is forbidden in Genesis 9:3-5 and Acts 15:20-29 of the *Old Testament*. For a discussion on Jehovah's Witness policy, see Lee Elder, "Why Some Jehovah's Witnesses Accept Blood and Conscientiously Reject Official Watchtower Society Blood Policy" (2000) 26 Journal of Medical Ethics 375-380, and also The Watchman Expositor, "The Watchtower Society's New Policy on Blood Transfusions" (2000), online: The Watchman Expositor

faced without certain modern medical treatments, namely those requiring the reception of blood. Further, they see this rejection of blood as risking harm only to the individual, and to nobody else (although this might be contested from a relational point of view).[64]

Given the above, and as noted by Justice Binnie,[65] the interference with A.C.'s religious conscience far exceeded the "non-trivial". However, the freedom of religion claim received scant attention in the two concurring judgments,[66] the majority contending that allowing evidence of maturity was sufficient to dispose of it. Given the patently *poor* record of judicial vindication of religious beliefs in the medical context, particularly those of Jehovah's Witnesses,[67] one would have hoped for a much more thoughtful consideration of the interaction between faith, religious community practices, best interests, minors, and medical treatment. One is left wondering: What is really happening with freedom of religion insofar as its enjoyment by minors is concerned?

We might speculate that the judiciary, which appears to adopt a largely secular, humanist stance, is somewhat suspicious that the (often archaic and dogmatic) religious beliefs which restrain mature minors like A.C. from accepting treatment are often inappropriately considered or only partially understood, or indeed are not personally held with sufficient conviction; these issues are difficult to test in individuals who are not yet fully socially or morally formed, and the best interests approach would seem to necessitate such an assessment, which is jettisoned once the individual reaches maturity.[68]

We might speculate that the judiciary is reluctant to allow minors to make irreversible decisions based on beliefs that some would characterize as superstition and that others would characterize as scriptural misinterpretations; decisions that, upon a reading of the cases, most courts would consider unwise.

Alternatively, judicial resistance to accepting refusals from minors in a highly religious environment may stem from the perception that observance (or subservience) to a scripted religion may circumscribe the minor's horizons, which is to say her ability to seek and consider broader opinions and to think critically, or perhaps rationally.[69] It is certainly recognized that social con-

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<http://www.watchman.org/jw/jwtransfusions2000.htm>.

[64] For more on Jehovah's Witness policy, see "Are you Resisting the Spirit of the World?" *The Watchtower* (1 April 1994) 16; see also "Questions from Readers" *The Watchtower* (15 June 2000) 29.

[65] *AC*, *supra* note 3 at para. 215.

[66] See *ibid.* at paras. 112-13, Abella J; see also paras. 153-56, McLachlin C.J.C.

[67] See *ibid.* at paras. 57, 59, 62, Abella J. The characterization of the record as 'poor' is based purely on the fact that most s. 2(a) challenges regarding treatment of minors have not succeeded with the result that, while that life may have been saved (a positive result from many perspectives), that individual's (and his or her parents') s. 2(a) rights have been overridden in a very fundamental way. Ultimately, no court in either the U.K. or Canada has upheld the refusal of a minor (under 16) of medical treatment that was likely to preserve his or her prospects for a normal and healthy future; concomitantly, courts have upheld a minor's wishes where those wishes are adjudged to be consistent with the minor's best interests, largely determined to be continued life.

[68] See *Malette*, *supra* note 30 (the Ontario Court of Appeal awarded damages for battery to a Jehovah's Witness who received blood against her express wishes). We might take notice that, regardless of the suspicion with which courts might view religious dogma, they do permit competent adults to refuse treatment.

[69] See T.H. McLaughlin, "Parental Rights and Religious Upbringing of Children" (1984) 18 Journal of Philosophy of Education 75, and Margaret Brazier & Caroline Bridge, "Coercion or Caring: Analysing Adolescent Autonomy" in Michael Freeman, ed., *Children, Medicine and the Law* (Aldershot: Ashgate, 2005) 461; *Re T.D.D.* (1999), 171 D.L.R. (4th) 761 (Sask. Q.B.), [1999] 6 W.W.R. 327 (Experts concluded that TD was less mature than the average 13 year-old because his social experiences were limited to his family and church, and he was deeply under the influence of his father, who was providing him with inaccurate information about risks and options. The Court concluded that this situation left TD with a lack of understanding or appreciation of the medical treatment he required. Thus, he was considered a minor unable to consent or refuse consent to treatment. The case does nothing to assuage the perception that religion circumscribes critical-thinking on the part of minors.); see also *Alberta (Director of Child Welfare) v. H. (B.)* (2002), 329 A.R. 395 (Q.B.), [2002] 7

text has a strong influence on minors and their competency, and social pressures can come from family or peer groups or religious institutions, often invisible or opaque.[70]

The point is that, while the measurable result is that we give rhetorical pre-eminence to autonomy (and some weight to religious freedom), we contract that autonomy when the resultant decision is seemingly irrational *and* based on religious tenets. Greater clarity around the interaction of these values and rights, and their exercise by minors (and adults) would have been welcome and useful.

Justice Abella noted that certain scholars advance the position that minors should be permitted to exercise their autonomy only insofar as it does not threaten their life or health.[71] While seriously denting our notional compliance with autonomy, this would be more intellectually honest insofar as present practices seem to approach the issue of medical treatment of minors on that footing. Similarly, present practices seem to equate best interests with continued life, often with little overt consideration of other relevant factors[72] including ongoing familial relationships and conceptions of "the good death", which is a significant feature of some cultures.[73]

Finally, one *might* question the wisdom of "saving" the (religious) child if she is subsequently shunned by family and excluded from other valued social and spiritual contexts, or, more tragically, forced to endure a life in fear that she has lost her immortal soul and place in heaven. We have no evidence concerning A.C.'s post-recovery situation. Despite the transfusion is she accepted by her family and/or her church? Does her faith continue to buoy her? Does she still believe that God is with her or will save her come the end? This is an area where empirical evidence might improve future adjudication. Having said that, the heterogeneity of Jehovah's Witness communities has been noted, and "pardons" have been extended to both adults and minors who have received blood products.[74]

CONCLUSION: TREATING KIDS LIKE KIDS

Whatever its shortcomings, the consequence of this case is to constitutionally ground an extension to mature minors of the right to participate in decisions with respect to their medical care; its broad stroke is to further entrench the concept of autonomy. However, it permits child welfare authorities to intervene on behalf of a minor (and in contradiction of her wishes) when it considers the minor's best interests to be better served by an alternate course (i.e., as determined by the court on evidence furnished by the authorities and operating *within* the statutory

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W.W.R. 616.

[70] See Jürgen Habermas, "Religion in the Public Sphere" (2006) 14 European Journal of Philosophy 1.

[71] *AC*, *supra* note 3 at para. 79 (Abella J. cites John Eekelaar, "The Emergence of Children's Rights" (1986) 6 Oxford J. Legal Stud. 161); see also *H. (T.) v. Children's Aid Society of Metropolitan Toronto*, [1996] W.D.F.L. 2497, 138 D.L.R. (4th) 144 (Ont. Gen. Div.) (violating a minor's freedom of religion is justified where the intent is to save or preserve her life); *Cf. Procureur General du Canada c. Hôpital Notre-Dame et un autre*, [1984] C.S. 426 (Qué. C.S.), 8 C.R.R. 382 (a case concerning a non-minor that held that as a matter of public policy sanctity of life, equated by some with inviolability, could override autonomy).

[72] See *Re Y. (A.)* (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. S.C.), 348 A.P.R. 91 (a Jehovah's Witness boy was undergoing chemotherapy which was anticipated to have only a 10-40% chance of inhibiting the progress of the cancer), which demonstrates that usually, other factors are only considered in cases where the chances of survival are slim.

[73] See Karen E. Steinhauser *et al.*, "In Search of a Good Death: Observations of Patients, Families and Providers" (2000) 132 Annals of Internal Medicine 825; Tony Walter, "Historical and Cultural Variants on the Good Death" (2003) 327 British Medical Journal 218; Kathryn Proulx & Cynthia Jacelon, "Dying with Dignity: The Good Patient Versus the Good Death" (2004) 21 American Journal of Hospice & Palliative Medicine 116; Susan Orpett Long, "Cultural Scripts for a Good Death in Japan and the United States: Similarities and Differences" (2004) 58 Social Science & Medicine 913.

[74] See Kenneth S. Hickey & Laurie Lyckholm, "Child Welfare Versus Parental Autonomy: Medical Ethics, the Law, and Faith-Based Healing" (2004) 25 Theoretical Medicine 265 at 271.

structure as interpreted by the SCC). Like the Court itself, and as perhaps is apparent, I have a certain level of inner conflict—of ambiguity—toward this final disposition.

On the one hand, the protection of autonomy rights is one of the most important means of respecting individuals, and we should not be reticent to vindicate those rights, even when we disagree with them (so long as their exercise does not harm another). Further, the law should reflect social reality, which is complex, even when this injects some uncertainty into the law; the complex reality is that young people are required to navigate through an increasingly complicated and demanding world, and they are expected to process and cope with ever-increasing amounts of information, and, as such, they are increasingly sophisticated and independent-minded.[75] Therefore, we should be reluctant to force them to bow to the will of adults (or courts) who may, given their own circumstances, know little better than the minor, or who have their own interests rather than the minor's at heart, or who may be vindicating their own values, to which the minor may not subscribe. From this perspective, autonomy generally, and the autonomy rights of minors more specifically (including A.C.'s), have been dealt a regrettable body blow.

On the other hand, in a hard world where life is diminishing in value, it is heartening to believe that we still harbour a respect for life, that we wish to preserve health and possibilities for individual human flourishing, and that we strive to protect vulnerable groups (like children). While young people are developing earlier and face greater challenges than before, and while we should respect them and treat them well and kindly (and even as equals where circumstances merit it), we should never forget that they are still children, and not fully formed (i.e. most people, upon coming into the fullness of their faculties and having experienced a bit more of life do not hold the same opinions about life and the world that they did when they were fifteen years old). While we should vindicate rights, including rights to exercise religion and to refuse unwanted medical treatment, thereby protecting autonomy (and liberty and security of the person), we might properly stop short when the natural result is the death of a young person who could be healed, and who (we believe) has everything ahead of them. In such cases, there is no disgrace in treating them as children; we should exercise judgment intended to help them and keep them alive.

Ultimately, the *CFSA*, as interpreted by the SCC, recognizes the capacity of a minor and permits her to exercise it. Perhaps it represents our best efforts to reconcile autonomy in younger people with our benevolent and paternalistic desire to protect them, and in doing so shows them "sufficient" respect. Perhaps, in the end, we should just "let kids be kids" and not worry that their autonomy rights have been dealt a blow.

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[75] For more on the development of youth and their status in the complex modern world, see Reuven Kahane, *The Origins of Postmodern Youth: Informal Youth Movements in a Comparative Perspective* (Berlin: De Gruyter, 1997); see also Frank Biocca, "New Media Technology and Youth: Trends in the Evolution of New Media" (2000) 27 Journal of Adolescent Health 22.

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