

BEST INTERESTS OR AUTONOMY? NAVIGATING PARENTING DISPUTES OVER CHILDREN'S TREATMENT

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TOPIC AND IMPORTANCE

Canadian family courts face recurring challenges in parenting disputes over children's medical treatment, often stemming from the overlap—and at times, conflict—between family law and health law. Family law applies the “best interests of the child” standard, directing judges to prioritize a child's welfare even over their expressed wishes. Health law, by contrast, recognizes the autonomy of mature or “capable minors” (individuals under 18 deemed legally competent to make decisions for themselves) to manage their own treatment, even when a parent might object.

Without a consistent standard, courts across the country have reached unpredictable and often conflicting outcomes in similar decisions. These inconsistencies directly affect children, as excluding young people from medical decision-making undermines the control they have over their own bodies. This article proposes a more coherent framework for medical decision-making in family law cases that defers to capable minors *and* reserves a “best interests” analysis that centres autonomy for those lacking the ability to make their own decisions.

MAIN ARGUMENTS

Recent cases show courts adopting three distinct approaches to these disputes. One line of decisions reflects a focus on health law, giving priority to a mature minor's capacity to choose. For example, Ontario's *Warren v. Charlton* held that a child's decision could override parental objections, while the British Columbia Court of Appeal in *A.B. v. C.D.* similarly deferred to professional assessments of maturity that supported a child's treatment choice.

Other courts have taken a more blended approach by applying the “best interests of the child” test while incorporating the health law principles of autonomy and capacity. The Supreme Court of Canada set the broader foundation in a child protection case, *A.C. v. Manitoba*, endorsing a sliding-scale model in which the weight attached to a child's

views increases with maturity or age. Various Ontario decisions such as *J.N. v. C.G.*, *M.M. v. W.A.K.*, and *Rouse v. Howard*, which attempted to balance welfare considerations with meaningful attention to a child's developing decision-making ability, reflect this approach.

However, more courts apply family law alone, often focusing narrowly on welfare without explicit reference to autonomy. In *P.R. v. S.R.* (Prince Edward Island) and *J.N. v. C.G.* (Ontario), judges granted decision-making authority to one parent despite the child's own expressed wishes, demonstrating how reliance on family law alone can sideline children's voices in treatment disputes.

This article calls for greater consistency across these differing (and often opposing) approaches, arguing that courts should begin by determining whether the child has the capacity to consent. If capable, health law should govern, and the child's decision should prevail. If not, family law should apply, but autonomy must remain a central consideration within the "best interests" analysis.

CONCLUSION AND ADDITIONAL CONSIDERATIONS

While Canadian courts have gone between health law, family law, and hybrid approaches, a framework that focuses mostly on a child's capacity to choose for themselves would resolve these tensions. Deferring to capable minors respects autonomy, reduces provincial disparities, and aligns with existing health law principles. For incapable children, weaving autonomy into the "best interests" test ensures their views remain meaningful without displacing necessary protections. This roadmap offers courts greater consistency while supporting children's development as autonomous decision-makers.