This article previously appeared in the June 2012 edition of Lexis Nexis Canada’s *Risk Management in Canadian Health Care* and has been re-printed with the author and publisher’s kind permission.

## Treatment of Adolescents with Anorexia Nervosa

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Under the *Health Care Consent Act (HCCA)*, every person is presumed to have the capacity to make a decision with respect to his or her treatment, including a child, unless there are reasonable grounds to believe otherwise. A person will be considered capable to make decisions with respect to a treatment, if he or she is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. If a person fails either branch of this test, a person is incapable of consenting to his or her own treatment. Where a patient is an infant, it is obvious that the child lacks the capacity to make his or her own treatment decisions. However, a determination as to whether an adolescent has the requisite capacity may not be so simple. If capable, adolescents can make decisions with respect to their treatment even if the decision could arguably lead to a negative outcome. If a health practitioner determines that an adolescent is incapable to make treatment decisions, the adolescent may apply to the Consent and Capacity Board (CCB) for a review of that decision.

Some of the most challenging cases that health practitioners face involve adolescents diagnosed with anorexia nervosa, a condition characterized by self-imposed restriction of food intake and the refusal of treatment that would result in weight gain. Although there are some exceptions, in the majority of these types of cases that come before the CCB, adolescent patients are found to be incapable of consenting to the proposed treatment on the basis that they are unable to appreciate the reasonably foreseeable consequences of their decision, as they tend to deny that they suffer from an eating disorder. Typically, a parent becomes the substitute decision-maker (SDM) of the incapable adolescent and is required to act in their child’s “best interests” as defined in the *HCCA*. Unfortunately, some parents are also in denial about their child’s eating disorder. Applications to the CCB or the Courts may therefore be necessary, to the extent that the SDM may not be acting in the best interests of the child in accordance with the *HCCA*.

Where an adolescent has been determined to be incapable of making treatment decisions relating to anorexia nervosa, and conflicts regarding treatment arise between the health practitioner and the parent as SDM, the health practitioner can apply to the CCB to request that a determination be made regarding whether a parent is making decisions in a manner that is compliant with the child’s best interests. Similarly, in situations where it is the adolescent who brings an application to have a parent appointed
as his/her representative, the health practitioner can oppose such application if there are concerns regarding whether the parent will act in the best interests of the child. For example, the treating physician may have evidence that a parent is a deterrent to his or her child becoming well, by repeatedly discharging them from the hospital or by believing assurances from the child that they can get better on their own.

In the recent case of *The Children’s Aid Society of the Niagara Region v. Jones*, the Society received a referral from a physician at McMaster Children’s Hospital Eating Disorder Clinic, where 15-year-old EJ was being treated for anorexia. Her parents refused the physician’s recommended treatment of their child’s condition. At the time, EJ’s situation was described as being acute; she had low blood pressure and low glucose levels. In addition, she was underweight and had a low heart rate. She was diagnosed as suffering from anorexia and had been restricting her food intake almost to the point of consuming no food. The physician expressed concern that EJ’s mother requested that EJ be discharged from the clinic against the hospital’s recommendations and that she had doubled EJ’s medication without the physician’s knowledge. As a result, the Society attempted to meet with EJ’s mother. However, the mother refused to discuss her decision not to return EJ to the hospital with the Society.

School officials had also been concerned with EJ’s medical condition. When they expressed these concerns to the mother, she was reportedly evasive and noncommittal and did not seem to recognize the seriousness of EJ’s eating disorder. She also allegedly failed to respond to other attempts by school officials to discuss EJ’s medical condition. The Society was later contacted by EJ’s school, who reported that EJ appeared emaciated, was losing hair, was pale, weighed about 70 pounds and had been taken out of school. The family doctor and EJ’s paediatrician confirmed that the mother was not in favour of the clinic’s further treatment of EJ, and that the mother was minimizing the seriousness of EJ’s condition.

The Society ultimately brought an application before the Superior Court of Justice seeking an interim supervision order. In the Court’s brief endorsement, Ramsey J. observed that since EJ’s parents were severely critical of both the Society and McMaster Hospital, EJ was therefore at risk. He concluded that an interim “without prejudice” supervision order was “well founded”. In January 2012, the Society withdrew its application since EJ’s health had been steadily improving since the parents were diligently following the medical recommendations regarding EJ’s care. While the Society’s intervention resulted in an improvement to EJ’s health, her parents did not welcome the intervention. The parents filed a claim for damages against the Society in the amount of $58,000 for lost income, legal fees, damages for invasion of privacy and compensation for compromising the family’s relationships with its health care professionals. The claim for damages was unsuccessful.

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1 Section 4(2) and (3) of the *Health Care Consent Act, 1996* (HCCA). This article does not address informal admission of a child under 16 to a psychiatric facility under the *Mental Health Act* by a substitute decision-maker for treatment purposes, or the secure detention and treatment provisions of the *Child and Family Services Act*. 

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ii Section 4(1) of the HCCA.

iii See, for example, Re HW 2005 CanLII 57736 (ON CCB).

iv See, for example, Re NZ 2012 CanLII 10561 (ON CCB).

v See s. 20 of the HCCA.

vi Section 21(2) of the HCCA.

vii This is known as a Form G. application. See, for example, Re WZ, 2010 CanLII 73135 (ON CCB). This also occurred in Re L, 2009 CanLII 67634 (review of treatment capacity) and 2009 CanLII 60752 (ON CCB) (appointment of representative), but was later abandoned when the parents agreed in writing with the proposed treatment. These types of applications trigger an application by the child to determine his/her capacity to consent to treatment unless the child’s capacity to consent to treatment has been determined by the CCB within the previous six (6) months (HCCA, s. 37.1).

viii Section 33(1) of the HCCA.

ix See, for example, Re L, 2009 CanLII 67634 (review of capacity) and 2009 CanLII 60752 (ON CCB) (appointment of representative).

x See, for example, Re VB, 2005 CanLII 57746 (ON CCB).

xi 2012 ONSC 1661 (CanLII) ("Jones").