Complementary and Alternative Health Care: The Rights of Patients and Parents to Refuse Medical Treatment

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By the

Alberta Civil Liberties Research Centre

Alberta
Civil Liberties
Research Centre
Mailing Address:
University of Calgary
2500 University Drive NW
Room 2350 Murray Fraser Hall
Calgary, Alberta T2N 1N4
p:(403) 220-2505
f:(403) 284-0945
e:aclrc@ucalgary.ca
www.aclrc.com

Acknowledgments

Dedication

This project is dedicated to the memory of Linda McKay-Panos, B.Ed., J.D., LL.M., Executive Director (1992-2024), whose vision, dedication, and contributions were integral to this report.

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I. Introduction

Health is a fundamental concern for every human being. While maintaining good health often requires following medical treatments and advice, an increasing number of people are turning away from conventional approaches in favour of alternative methods.

Many people around the world, particularly in Western countries, are turning to complementary and alternative medicine (CAM) and natural health products (NHPs) to treat their illnesses.

CAM practitioners such as massage therapists, acupuncturists, naturopaths and chiropractors are becoming increasingly popular among many people. Also, more people are buying NHPs which do not require a prescription from a health practitioner.

Patients dissatisfied with the current treatments offered by conventional medicine, such as cancer patients who are disappointed with conventional cancer treatment, have turned to complementary and alternative medicine in the hope of finding better treatments.[1]

The growing number of people using CAM treatments has prompted governments across the world, including Canada, and the World Health Organization (WHO) to regulate the use of these therapies and products.[2] In Canada, CAM has become an important health care issue due to the increasing number of patients who are seeking these practices and due to the growing number of

[1] Mainstreaming Alternative and Complementary Medicine (1 December 2019), online: ASH Clinical News <https://www.ashclinicalnews.org/spotlight/feature-articles/mainstreaming-alternative-complementary-medicine/ >.
[2] Cynthia Ramsay, *Unnatural Regulation: Complementary and Alternative Medicine Policy in Canada* (Vancouver: Fraser Institute, 2009), online: Fraser Institute <https://www.fraserinstitute.org/sites/default/files/UnnaturalRegulation.pdf > at 5 [Cynthia Ramsay].

practitioners in this field. These factors have pushed the Canadian government to consider the regulation of CAM.[3]

As a growing number of individuals are opting for CAM health care, more parents with sick children are rejecting conventional medical treatment for their children, in favor of alternative therapies for a variety of reasons. This trend has led to numerous court cases. Some parents who do not believe in conventional medicine and have refused conventional treatment for their sick child, have been convicted under section 215 of the *Criminal Code*[4]. Additionally, some Indigenous individuals and Indigenous parents have rejected conventional medicine in favor of traditional medicine.

The use of complementary and alternative medicine (CAM) by adult patients and traditional medicine by Indigenous peoples has generally not been a significant issue. However, parents of sick young children who choose CAM over conventional treatments often face legal challenges. This raises a critical question: Do parents have the right to refuse conventional medical treatment for their children in favor of alternative therapies, even when such decisions may jeopardize their children's lives or lead to death?

II. The Right to Health and Health Care

The right to health is recognized as a fundamental human right, and states have committed to protecting this right through domestic legislation, international declarations, and the ratification of international human rights treaties that affirm the right to health.

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[3] Heather Boon, "Regulation of Complementary/Alternative Medicine: A Canadian Perspective" (2020) 10 Complimentary Therapies in Medicine, online: ResearchGate <https://www.researchgate.net/publication/11025428_Regulation_of_complementaryalternative_medicine_A_Canadian_perspective> at 14 [Heather Boon].
[4] *Criminal Code*, RSC 1985, c C-46 [*Criminal Code*].

However, even though the right to health is an internationally recognized human right, Canada's Constitution does not mention this right.

A. The Right to Health is a Fundamental Human Right

The right to the highest attainable standard of health is a human right recognized in international human rights law.

The preamble of the 1946 Constitution of the WHO, states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". [5] The preamble also mentions that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[6]

Article 25 of the 1948 *Universal Declaration of Human Rights*[7] also states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…"

The *International Covenant on Economic, Social and Cultural Rights*[8], which is the main document of protection for the right to health, recognizes in article 12 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Article 24 of the *Convention on the Rights of the Child*[9] states:

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[5] Constitution of the World Health Organization, 22 July 1946, 14 UNTS 185 (entered into force 7 April 1948), online: <https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1> at 1 [WHO Constitution].
[6] WHO Constitution.
[7] *Universal Declaration of Human Rights*, GA Res 217 A (III), UNGAOR, 3rd Sess, UN Doc A/810, 10 December 1948, online: United Nations < https://www.un.org/en/universal-declaration-human-rights/>.
[8] *International Covenant on Economic, Social and Cultural Rights*, 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) online: United Nations Human Rights, Office of the High Commissioner < https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx> [*Convention Economic Social Cultural Rights*].
[9] *Convention on the Rights of the Child,* 20 November 1989*,* 1577 UNTS 3 (entered into force 2 September 1990), online: United Nations Human Rights, Office of the High Commissioner <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health-care services.
>
> 2. States Parties shall pursue full implementation of this right…

"Human rights are interdependent, indivisible and interrelated", therefore violating the right to health may affect the enjoyment of other human rights such as the right to work or education or have a family and vice versa.[10]

According to the Office of the United Nations High Commissioner for Human Rights and the WHO,

> the right to health contains freedoms. These freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment or punishment. [11]

Also, according to the WHO "the right to health means that everyone should be entitled to control their own health and body, including having access to sexual and reproductive information and services, free from violence and discrimination." [12]

The WHO added: "Everyone has the right to privacy and to be treated with respect and dignity. Nobody should be subjected to medical experimentation, forced medical examination, or given treatment without informed consent." [13]

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[10] *Vienna Declaration and Programme of Action*, World Conference on Human Rights, 25 June 1993, UN Doc A/CONF.157/23, online: United Nations Human Rights, Office of the High Commissioner <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx> at article 5.
[11] *Fact Sheet No. 31: The Right to Health*, Office of the United Nations High Commissioner for Human Rights and World Health Organization, online: OHCHR< https://www.ohchr.org/Documents/Publications/Factsheet31.pdf > at 3.
[12] World Health Organization, Health is a Fundamental Human Right (10 December 2017), online: <https://www.who.int/news-room/commentaries/detail/health-is-a-fundamental-human-right#:~:text=The%20right%20to%20health%20also,treated%20with%20respect%20and%20dignity> [Health is a Fundamental Human Right].
[13] Health is a Fundamental Human Right.

B. In Canada

As a human right, all Canadians have the right to health and the federal government must make sure that all Canadians have access to this right.

The *Constitution Act* of 1867[14] did not include health among the legislative powers given to Parliament in section 91 or to the Provincial Legislatures in section 92.

Further, there is no explicit right to health care under the *Canadian Charter of Rights and Freedoms*[15] (the *Charter*).

Despite the absence of a clear constitutional right to health, Canada has enacted legislation that aims to safeguard access to healthcare for its citizens. In its preamble, the *Canada Health Act*[16] states:

> continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.

Section 3 of the *Act* further affirms that:

> the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.[17]

While the right to health is not explicitly stated in the Canadian *Constitution*, it is defined and protected by international human rights conventions that Canada has ratified. These conventions impose binding obligations on Canada to uphold the right to health.

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[14] *Constitution Act*, 1867 (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No. 5.
[15] *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11 [*Charter*].
[16] *Canada Health Act*, RSC 1985, c C-6 [*Canada Health Act*].
[17] *Canada Health Act*.

Article 2 (1) of the *International Covenant on Economic, Social and Cultural Rights* asserts that "States have the obligation to progressively achieve the full realization of the rights under the Covenant." [18]

However, the obligations imposed by international human rights treaties are not directly enforceable under Canadian law. The government cannot be found guilty by the judicial system, of breaching the right to health. Nonetheless, Canadian courts have interpreted the *Charter* and domestic laws that protect the right to health and Canada's international legal obligations.[19]

In *Schneider v The Queen*, the Supreme Court of Canada stated:

> … "health" is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question. [20]

This was affirmed by the Supreme Court in *Chaoulli v Quebec (Attorney General)*:

> The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*. [21]

In *Baier v Alberta*[22], Alberta Court of Appeal upheld this decision.

These cases highlight the role of Canadian courts in interpreting and protecting the right to health under the *Charter*.

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[18] *Convention Economic Social Cultural Rights*.
[19] Vanessa Abban, "Getting it Right: What Does the Right to Health Mean for Canadians? " (March 2015), online: Wellesley Institute < https://www.wellesleyinstitute.com/wp-content/uploads/2015/03/Rights-Based-Approach-to-Health_Wellesley-Institute_2015-1.pdf> at 6.
[20] *Schneider v The Queen*, 1982 CanLII 26 (SCC), [1982] 2 SCR 112 at p 142.
[21] *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 (CanLII), [2005] 1 SCR 791 at para 104.
[22] *Baier v Alberta*, 2006 ABCA 137 (CanLII) at para 44.

III. Western, Complementary, Alternative, Traditional Medicine and Natural Health Products

Today, we commonly encounter two main categories of medicine: 1) Western, mainstream and conventional medicine; 2) traditional, alternative and complementary medicine. Additionally, there are also Natural Health Products (NHPs).

A. Definitions

i. Western or Conventional Medicine

According to the WHO, conventional medicine is

> the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.[23]

Today, Western or conventional medicine is practiced and studied around the world. It is linked to biomedicine[24] and clinical research. It is considered as a primary method of medical care.[25]

ii. Complementary and Alternative Medicine

According to the WHO, complementary or alternative medicine refers to

> a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-

[23] World Health Organization, Traditional, Complementary and Integrative Medicine, online: < https://www.who.int/Health-Topics/Traditional-Complementary-and-Integrative-Medicine#tab=tab_1 >.[WHO].
[24] Study.eu, Study Biomedicine or Biomedical Sciences: All you Need to Know, online: <https://www.study.eu/article/study-biomedicine-or-biomedical-sciences>. Biomedical Science (Biomedicine) is the field of study that focuses on the areas of biology and chemistry that are relevant to healthcare.
[25] Zachary Stansfield et al., "An Overview of Complementary and Alternative Medicines", online: The University of British Columbia, Faculty of Medicine, Medical Journal <https://ubcmj.med.ubc.ca/ubcmj-volume-7-issue-1/an-overview-of-complementary-and-alternative-medicines/an-overview-of-complementary-and-alternative-medicines/> [Zachary Stansfield].

> care system. They are used interchangeably with traditional medicine in some countries.[26]

Other terms are also used for CAM such as "natural medicine", "non-conventional medicine" and "holistic medicine."[27]

Complementary medicine is a practice used along with conventional health care, while alternative medicine is a practice used in place of conventional health care.[28]

CAM therapies can be classified into five categories:

> (1) alternative medical systems (e.g., homeopathy, naturopathy and traditional Chinese medicine), (2) mind-body interventions, (3) biologically based therapies (e.g., foods, vitamins, herbs), (4) manipulative and body-based methods (e.g., chiropractic, massage) and (5) energy therapies (e.g., therapeutic touch, qigong)."[29]

It is important to note that CAM practices are diverse and are often not accepted by conventional medicine practitioners. However, these practices still require regulation to ensure their safety and efficacy.[30]

iii. Traditional Medicine

Traditional medicine is defined by the WHO as:

> the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.[31]

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[26] WHO.
[27] Raymond Obomsawin, "Traditional Medicine for Canada's First Peoples (March 2007), online: <http://lfs-indigenous.sites.olt.ubc.ca/files/2014/07/RayObomsawin.traditional.medicine-1.pdf> at p 26 [Raymond Obomsawin].
[28] Complementary and Alternative Health Care and Natural Health Products Standards, online: College & Association of Registered Nurses of Alberta < complementary-and-alternative-health-care-and-natural-health-products-standards-2022.pdf > at 5 [Registered Nurses of Alberta].
[29] Heather S. Boon et al.,"Complementary and Alternative Medicine: A Rising Healthcare Issue" (April 2006) 1(3), online: Longwoods.com <https://www.longwoods.com/content/18120/healthcare-policy/complementary-and-alternative-medicine-a-rising-healthcare-issue>.
[30] Zachary Stansfield.
[31] WHO.

Indigenous traditional medicine encompasses a diverse range of medical practices developed by Indigenous peoples, with a focus on holistic approaches to health.[32] These practices can vary between communities, and may include herbal medicines, sweat baths or lodges and psychological and spiritual counselling through ritual ceremonies led by elders or specialized practitioners.[33]

iv. Natural Health Products

Natural Health Products include different products that are used by Canadians, such as herbal medicines, homeopathic remedies and nutritional supplements.[34]

NHPs are "made from plants but can also be made from other sources such as animals, microorganisms, and marine sources."[35] NHPs can include vitamins, minerals, probiotics, and herbal medicines.

In the past, NHPs were primarily viewed as food. However, as these products started making health claims, they began to be treated as drugs, placing them in a "regulatory grey area."[36]

In 1997, the federal government established a Standing Committee on Health to examine issues related to the manufacture, distribution, and use of NHPs. In 1998, the Committee combined 53 recommendations, including the establishment of a new regulatory authority. In 1999, the office of the Natural Health Products Directorate (previously the Office of Natural

[32] Zachary Stansfield.
[33] Zachary Stansfield.
[34] Archived – Complementary and Alternative Health Care: The Other Mainstream?, online: Government of Canada <https://www.canada.ca/en/health-canada/services/science-research/reports-publications/health-policy-research/complementary-alternative-health-care-other-mainstream.html>.
[35] Registered Nurses of Alberta at 6.
[36] Cynthia Ramsay at 16.

Health Products) was created. Then in 2004, the Directorate's new Natural Health Products Regulations (NHPR) took place.[37]

The role of the Natural Health Products Directorate is "to ensure that Canadians have ready access to natural health products that are safe, effective and of high quality while respecting freedom of choice and philosophical and cultural diversity." [38] However, many Canadians started using NHPs and CAM before any regulations were implemented by the government.

B. Regulation by the Canadian Government

According to the 2017 Fraser Institute report,

> more than three-quarters of Canadians (79%) had used at least one complementary or alternative therapy sometime in their lives in 2016. This compares to 74% in 2006 and 73% in 1997. Among the provinces in 2016, British Columbians were most likely to have used an alternative therapy during their lifetime (89%), followed by Albertans (84%) and Ontarians (81%).[39]

The report added that Canadians spent around $8.8 billion on CAM between the latter half of 2015 and first half of 2016.

People choose to use CAM for various reasons, such as distrust of doctors, belief in holistic health, or curiosity about these practices. Most Canadians reported using CAM in addition to conventional medicine. [40]

CAM practice has become a significant health issue in Canada since more and more Canadians are choosing this practice, and more practitioners are working in the field.[41]

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[37] Cynthia Ramsay at 16.
[38] Cynthia Ramsay at 5.
[39] Nadeem Esmail, "Complementary and Alternative Medicine: Use and Public Attitudes 1997, 2006, and 2016" (25 April 2017), online: Fraser Institute <https://www.fraserinstitute.org/studies/complementary-and-alternative-medicine-use-and-public-attitudes-1997-2006-and-2016>.
[40] Complementary and Alternative Medicine (Update 2015), online: Canadian Medical Association <https://policybase.cma.ca/link/policy11529 > at 2.
[41] Heather Boon at 14.

According to Jo et al.:

> The World Health Organization (WHO) contends that while CAM has grown in popularity, public understanding of the risks associated with it have not kept up with its demand. Unequal regulation guidelines, misleading titles, and perpetuation of misinformation create an unsteady foundation for the legitimacy of CAM, which often translates to a perception of certain practices being illegitimate.[42]

In Canada, natural health products are regulated by the federal government.[43] The *Natural Health Products Regulations*[44] manage how NHPs products are to be used by Canadians and make sure that these products are safe, effective and of high quality.

Conversely, CAM professions are regulated by provincial governments where they have the power to establish Colleges and regulatory bodies to determine the requirements for licensing of CAM practitioners and the extent of their practice. In order to be eligible for regulation, CAM practitioners must "fall within the definition of a 'health profession'".[45]

Provinces have different regulations when it comes to CAM practitioners. Some CAM practices might be regulated in one province but not in another. This can create difficulties for some CAM practitioners to move between provinces and cause uncertainty among individuals seeking medical therapies in other provinces.[46]

In provinces where there are no CAM regulations, anyone who wants to practice CAM can do so without any restrictions or supervision. This lack of regulation can allow untrained practitioners to provide services to the public. For example, a practicing naturopath can get

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[42] Min Jo et al., "Alternative Medicine Should be Tightly Regulated", online: Western University Canada, IVEY Business School <https://www.ivey.uwo.ca/cmsmedia/3490163/alternative-medicine-thought-piece.pdf> at 2 [Min Jo].
[43] Heather Boon at 14-15.
[44] *Natural Health Products Regulations,* SOR/2003-196.
[45] Min Jo at 2.
[46] Heather Boon at 14-15.

training at an accredited college, while other practitioners might only complete a weekend course, and others may receive no training at all.[47]

Moreover, each regulated CAM profession has a "code of conduct that outlines the profession's scope of practice; this includes details as to when a referral should be made."[48] Unregulated practitioners are not subject to such codes and do not have to make referrals in the same way. Further, unregulated practitioners may make inappropriate claims about the effectiveness of their treatment without scientific evidence.[49]

According to the College & Association of Registered Nurses of Alberta:

> Any person or company that manufactures, packages, labels, and/or imports NHPs for commercial sale in Canada, must meet the licensing requirements set out in the regulations. To obtain a license, applicants' detailed information must be given to Health Canada, e.g., medicinal ingredients, source, dose, potency, non-medicinal ingredients, and recommended use(s). Once the product is approved by Health Canada, it is issued an eight-digit Natural Product Number (NPN) or Homeopathic Medicine Number (DIN-HM) which will be printed on the product label.[50]

In Alberta there are regulatory colleges for Acupuncture, Chiropractic medicine, and Naturopathic medicine.

C. Examples of Parents Who Choose CAM

Despite the lack of regulation, the growing popularity of CAM practices has led some parents to choose alternative therapies for their sick children instead of conventional treatments. For example, many parents of children with autism seek alternative therapies such as vitamins, herbal supplements, special diets, antibiotics and antifungals. There are no regulations in Canada

[47] Min Jo at 2.
[48] Min Jo at 3.
[49] Min Jo at 3.
[50] Registered Nurses of Alberta at 6.

to determine what treatments are effective for autism, aside from conventional options like speech therapy. As a result, these parents often find themselves vulnerable, resorting to whatever treatments are available to them.

In 2008, Sandra Hart of Ontario took her 9-year-old son, who had severely limited verbal skills, to a chiropractor who claimed he could correct autism with cranial adjustments[51]. According to Hart, "she spent more than $5,000 on the chiropractor within a year, and hundreds of dollars on testing and buying nutritional supplements for her son."[52] Hart admitted that she couldn't tell whether the treatments helped her son's verbal skills since he was seeing a speech therapist at the same time.

Similarly, Cathy Wright took out a line of credit to pay for alternative therapies for her son Isaac during his childhood. Wright paid up to $10,000 over the years, not counting food for special diets that a naturopath recommended. Wright expressed her frustration, stating, "it seemed the mainstream health-care system had written off Isaac, and that there wasn't much more that could be done to help him."[53]

Many parents also pursue chelation therapy[54] for autism, even though there is no scientific evidence to support it. Health Canada has stated that it "has not authorized any chelation therapy drugs or natural health products for use in children as treatment for

[51] 3D Integrated Medical, online: <https://3dintegratedmedical.com/cranial-adjustments/#:~:text=Cranial%20adjustments%20are%20a%20form,are%20not%20fixed%20or%20fused>; Cranial adjustments are a "form of chiropractic treatment used to treat misalignments within the skull or face as these misalignments can lead to a wealth of health problems when not treated."
[52] Vik Adhopia, "Why Doctors Need to Walk a 'Fine Line' When Talking to Parents About Alternative Therapies for Autism", (15 November 2019), online: CBC News <https://www.cbc.ca/news/health/pediatric-society-alternative-autism-1.5360115> [Vik Adhopia].
[53] Vik Adhopia.
[54] What Does Chelation Therapy Treat? online: healthline <https://www.healthline.com/health/chelation-therapy>. "Chelation therapy is a method for removing heavy metals, such as mercury or lead, from blood."

autism." [55] In addition, parents could spend a lot of money for an ineffective treatment since chelation therapy is not covered by drug plans for autism.

Since CAM practices are either unregulated or regulated differently across provinces, patients and parents of sick children are often left vulnerable. This can lead them to spend significant amounts of money on unsuccessful therapies.

IV. Medical treatment and Adults in Canada

Adults in Canada, who have the capacity to make their own medical decisions have the right to accept or refuse any medical treatment for any reason. However, this decision must be made freely by the adult, without any fear, undue influence, duress or misrepresentation. Additionally, before deciding, the adult must be fully informed about the risks and benefits of the medical treatment.[56]

A. The Rights of Adults to Refuse Medical Treatment

According to *Canada Health Act*, residents of Canada have a right to a reasonable level of health care.

In most provinces, patients have the sole right to reject or consent to medical treatments, as long as they have the capacity to understand the nature of the treatment, even if refusal means their health will decline or even if it can lead to death.[57]

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[55] Nicole Ireland, "Treatment to Remove Metals from Children with Autism Unproven and Risky, but no Clear Regulations" (30 August 2018), online: CBC News <https://www.cbc.ca/news/health/autism-chelation-therapy-unproven-and-dangerous-1.4803423>.

[56] David C. Day, "The Capable Minor's Healthcare: Who Decides?" (2007) 86:3, online: The Canadian Bar Review <http://lewisday.ca/ldlf_files/CapableMinors/CapbleMinors.pdf>.
at 391 [David C. Day].

[57] Consenting or Refusing Health Treatment, online: Legalline.ca <https://www.legalline.ca/legal-answers/consenting-or-refusing-health-treatment/> [Legalline.ca].

Healthcare laws and regulations are different between provinces and territories, but they all share the following rights:

> The right to be fully informed of all treatment options. This is also known as the 'right of informed consent.' A healthcare professional is required to inform you of the risks and benefits of each diagnostic procedure or test, and treatment option as well as the probabilities of success and failure.
>
> …
>
> The right to refuse treatment. You have the right to refuse any treatment, even if refusal might hasten your death. You also have the right to discontinue any treatment, test or procedure that has already started.[58]

Patients can only consent to medical treatment if they have learned about it ahead of time. This includes a "full explanation of the treatment, the risks associated with the treatment, the risks of not accepting treatment, and information about alternative treatments."[59]

B. Caselaw

Courts in Canada have given competent adults the right to refuse a medical treatment, or to discontinue their treatment once started even if that may result in death.

In *Malette v Shulman*, [60] Mrs. Malette got into a car accident and arrived at the hospital unconscious. She carried a card with her, identifying her as a Jehovah's Witness and requesting that she not be given a blood transfusion under any circumstances. Despite that, the doctor decided to give her a blood transfusion. He was held liable for battery.

The Ontario Court of Appeal stated:

> A competent adult is generally entitled to reject a specific treatment or all treatment or to select an alternate form of treatment even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical

[58] Your Rights as a Patient, online: Canadian Health Advocates Inc <https://www.canadianhealthadvocatesinc.ca/post/your-rights-as-a-patient >.
[59] Legalline.ca.
[60] *Malette v Shulman (Ont. C.A.)*, 1990 CanLII 6868 (ON CA) [*Malette v Shulman*].

> profession or of the community. Regardless of the doctor's opinion it is the patient who has the final say on whether to undergo the treatment.[61]

In *Starson v Swayze,*[62] the Supreme Court said that the "right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy."

The Court added:

> Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information ... Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.[63]

Patients have the right to refuse medical treatment, but they must do so after being informed of the benefits and risks involved in the treatment. This was established in *Hopp v Lepp* where the Supreme Court affirmed the following:

> The term "informed consent", frequently used in American cases, reflects the fact that although there is, generally, prior consent by a patient to proposed surgery or therapy, this does not immunize a surgeon or physician from liability for battery or for negligence if he has failed in a duty to disclose risks of the surgery or treatment, known or which should be known to him, and which are unknown to the patient. The underlying principle is the right of a patient to decide what, if anything, should be done with his body … It follows, therefore, that a patient's consent, whether to surgery or to therapy, will give protection to his surgeon or physician only if the patient has been sufficiently informed to enable him to make a choice whether or not to submit to the surgery or therapy. The issue of informed consent is at bottom a question whether there is a duty of disclosure, a duty by the surgeon or physician to provide information and, if so, the extent or scope of the duty.[64]

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[61] *Malette v Shulman*.
[62] *Starson v Swayze*, 2003 SCC 32 (CanLII), [2003] 1 SCR 722 at para 75 [*Starson v Swayze*].
[63] *Starson v Swayze* at para 78.
[64] *Hopp v* Lepp, 1980 CanLII 14 (SCC), [1980] 2 SCR 192 at p 196.

That was confirmed in *Hollis v Dow Corning Corp*:

> … physicians have a duty, without being questioned, to disclose to a patient the material risks of a proposed procedure, its gravity, and any special or unusual risks, including risks with a low probability of occurrence, attendant upon the performance of the procedure; see also *Ciarlariello v. Schacter*, 1993 CanLII 138 (SCC), [1993] 2 S.C.R. 119. The principle underlying "informed consent", as Laskin C.J. explained in *Hopp*, *supra*, at p. 196, is the "right of a patient to decide what, if anything, should be done with his body"; see also *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y.C.A. 1914), *per* Cardozo J. The doctrine of "informed consent" dictates that every individual has a right to know what risks are involved in undergoing or foregoing medical treatment and a concomitant right to make meaningful decisions based on a full understanding of those risks.[65]

This shows that adults have the authority to accept or refuse medical treatment, as long as they are capable of understanding the advantages and disadvantages of the treatment and are informed in advance of what is involved in the treatment. But what about mature minors?

V. Medical Treatment and Mature Minors in Canada

Minors traditionally did not have the right to make decisions about their medical treatment, as they were considered legally incompetent due to their age. Instead, parents or guardians held the exclusive authority to accept or refuse these treatments on their behalf. However, over the years, courts have recognized that children under 18 who possess the maturity and capacity to understand their medical options should have a voice in decisions regarding their own medical treatment.[66]

As a result of these court decisions, in situations when a mature minor makes a decision about their medical treatment, parents "become substitute decision makers and should respect

[65] *Hollis v Dow Corning Corp*., 1995 CanLII 55 (SCC), [1995] 4 SCR 634 at para 24.
[66] Kathryn Hickey, "Minors' Rights in Medical Decision Making" (2007) 9:3, online: JONAS's Healthcare Law <https://nursing.ceconnection.com/ovidfiles/00128488-200707000-00013.pdf> at 100 [Kathryn Hickey].

their child or adolescent's choice."[67] In addition, denying mature minors the right to decide on medical treatment is now seen as a violation of their fundamental rights.

A. The Mature Minor Doctrine

i. Informed Consent

Informed consent requires that a decision maker: "1) has capacity to make the decision, 2) is adequately informed, that is, given all relevant information that a reasonable person would require to make a decision, and 3) the resultant decision must be voluntary and free of coercion."[68]

The first step in this process is the minor patient's ability to understand what is involved in the treatment. The second step is that the minor patient be given all relevant information that a reasonable person would need to make a decision. The last requirement is that the minor patient makes a voluntary decision, free from their parents' influence.[69]

This transition of authority, and change in role of the parent, was outlined in *Van Mol v Ashmore*, where the Court of Appeal for British Columbia Court held:

> At common law, without any reference to statute law, a young person, still a minor, may give, on his or her own behalf, a fully informed consent to medical treatment if he or she has sufficient maturity, intelligence and capability of understanding what is involved in making informed choices about the proposed medical treatment. If a young person does not have that degree of maturity, intelligence, and capability of understanding, then that young person cannot give informed consent to proposed medical treatment, and the consent must be given by a parent or guardian. But once the required capacity to consent has been achieved by the young person reaching sufficient maturity, intelligence and capability of understanding, the discussions about the nature of the treatment, its gravity, the material risks and any special or unusual risks, and the decisions

[67] Paediatrics Child Health, "Treatment Decisions Regarding Infants, Children and Adolescents" (February 2004) 9:2, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2720471/>.
[68] Kevin W Coughlin, "Medical Decision-Making in Paediatrics: Infancy to Adolescence" (12 April 2018), online: Canadian Paediatric Society <https://www.cps.ca/en/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence> [Kevin W Coughlin].
[69] Kevin W Coughlin.

> about undergoing treatment, and about the form of the treatment, must all take place with and be made by the young person whose bodily integrity is to be invaded and whose life and health will be affected by the outcome. At that stage, the parent or guardian will no longer have any overriding right to give or withhold consent. All rights in relation to giving or withholding consent will then be held entirely by the child. The role of the parent or guardian is as advisor and friend. [70]

But who is considered a mature and capable minor?

ii. Who is a Mature Minor?

Generally, children are considered to lack capacity until they turn 7 years old. From seven to fourteen, children are subject to a rebuttable presumption of incapacity.[71] From fourteen to twenty-one, they are subject to a rebuttable presumption of capacity.[72]

Medical decision-making in adolescents is complicated. When medical treatments have no or low risks and when a therapy is straightforward, a 14-year-old can be regarded to have sufficient capacity to understand and consent. But when it comes to more complicated treatments, such as chemotherapy, a 14-year-old may not have the capacity to decide on such a treatment.

In common law, mature minors are adolescents 1) who have showed the ability to make decisions in different areas of life; 2) who are capable of understanding the nature and effects of medical treatment; and 3) who can give a valid consent.[73]

If a minor is able to understand the purpose of the medical treatment, its risks, short- and long-term consequences, benefits, and alternatives, they are considered mature enough to make an informed decision regarding medical treatment. Additionally, there must be evidence that the

[70] *Van Mol v Ashmore*, 1999 BCCA 6 (CanLII) at para 75.
[71] The rebuttable presumption of incapacity means that the individual or persons are presumed to lack the capacity to make decisions, although this presumption can be challenged; David C. Day at 381.
[72] The rebuttable presumption of capacity means that the individual or persons are presumed to be capable of making decisions, although this can be challenged; David C. Day at 381.
[73] Kevin W Coughlin.

minor can make the decision independently, without coercion. This level of maturity grants the minor the capacity to make decisions about their own medical treatment.[74]

David Day defined a mature minor as:

> A person under the common law age of majority who is capable of appreciating the nature and consequences of a particular operation or other treatment, whether recommended by the treating physician or chosen by the capable young person, can give an effective consent without anyone else's approval being required. Where the young person lacks that capacity, however, any apparent consent by her or him will be a nullity, in which event consent is required from the young person's personal guardian(s) or from the state.[75]

When it comes to the mature minor doctrine in provinces and territories, some have adopted an arbitrary age for medical decisions, while others have determined a rebuttable age of capacity.

B. The Mature Minor Doctrine in Different Provinces and Territories

Children generally have little capacity to exercise their rights and are considered legally incompetent until they reach a specified age of majority or demonstrate a particular level of maturity. However, the majority age and the required maturity level differ between provinces and territories.

Most provinces in Canada have specific legislation regarding consent to medical treatment. Also, all provinces and territories have child welfare legislation which defines "child" as a person under either sixteen, eighteen or nineteen.[76]

[74] Kathryn Hickey at 101-102.
[75] David C. Day at 382.
[76] David C. Day at 383.

i. Alberta

In Alberta, a mature minor who is not a "ward of a director under the Child, Youth and Family Enhancement Act" has the right to accept or refuse a medical treatment.[77] Parents or guardians do not have the authority to override the mature minor's medical decision.[78]

Alberta does not have a specified age for a mature minor. When it comes to medical treatments, the more serious the proposed treatment, the higher the level of maturity required to make an informed decision. Courts have generally acknowledged 16 years as the starting point for maturity, but none have recognized any adolescent younger than 14. For Child Welfare authorities in Alberta, children 12 years of age can be consulted on decisions that affect them, however the child's view is not decisive.[79]

ii. Ontario

Ontario's *Health Care Consent Act*[80] allows capable individuals of any age to decide for their own medical treatment. Some consider this *Act* "the most advanced legislation in the world in protecting the rights of both the capable or competent patient as well as the incapable or incompetent patient in the health care field."[81]

Ontario differs from many other provinces in its approach to children's health-care decisions. In most provinces, children must be recognized as mature minors in order to make decisions about their medical treatment. However, Ontario has a more flexible framework where, children

[77] Advice To the Profession: Informed Consent for Minors, (December 2016), online: College of Physicians & Surgeons of Alberta < https://cpsa.ca/wp-content/uploads/2020/06/AP_Informed-Consent-for-Minors.pdf> at 7 [Advice To the Profession].
[78] Advice To the Profession at 7.
[79] Advice To the Profession at 7.
[80] *Health Care Consent Act*, 1996, SO 1996, c. 2, Sched A, s 4 [*Health Care Consent Act*].
[81] David C. Day at 385.

are given complete control over their own health-care decisions unless a physician determines they are incapable.[82]

The *Health Care Consent Act*[83] does not allow any treatment without the consent of a capable person of any age. If an individual is unable to provide consent, a substitute decision-maker must provide consent on their behalf, in accordance with the provisions of the *Act*.

iii. British Columbia

According to the *Infants Act*[84] in British Columbia, minors (referred to as "infants" under the legislation) can make health care decisions if they understand the nature and consequences of the treatment. Health care providers must make sure that the treatment is in the best interests of the minor, therefore minors' decisions can be final if it is determined that the treatment is in their best interests.

iv. Quebec

According to the *Civil Code*[85] in Quebec, minors can consent to medical treatment at the age of 14. However, the court has the authority to overturn a minor's decision to refuse medical treatment if it is deemed to be in the best interests of the minor.[86]

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[82] Tim Alamenciak, "Ontario Law Allows Children to Determine Medical Care" (20 January 2015), online: The Star <https://www.thestar.com/news/gta/2015/01/20/ontario-law-allows-children-to-determine-medical-care.html>.
[83] *Health Care Consent Act* s 10(1).
[84] *Infants Act*, RSBC 1996, c 223, s 17.
[85] *Civil Code of Quebec*, SQ 1991, c 64, s 14 [*Civil Code of Quebec*].
[86] *Civil Code of Quebec* s 16.

v. Manitoba

In Manitoba, according to *The Health Care Directives Act*[87], minors who are under 16 years of age are presumed incapable of making health care decisions. However, this *Act* permits a minor *under* the age of 16 to rebut the presumption of incapacity.

vi. Saskatchewan

In Saskatchewan, according to the *Health Care Directives and Substitute Health Care Decision Makers Act*[88], minors who are 16 years old can make a health care directive.

vii. New Brunswick

In New Brunswick, the *Medical Consent of Minors Act*[89] grants minors aged 16 and older the same legal authority to consent to medical treatment as if they were 19 (the age of majority in that province). Minors who are younger than 16, can consent to medical treatment if, in the opinion of a legally qualified medical practitioner, they are capable of understanding the nature and consequences of the treatment and if the treatment is in their best interests.

viii. Prince Edward Island and the Yukon

Both Prince Edward Island, through the *Consent to Treatment and Health Care Directives Act*[90], and the Yukon, through the *Care Consent Act*[91] allow capable individuals of any age to decide on their medical treatment.

Due to the mature minor doctrine, there is an assumption that children are capable of deciding for their own medical treatment. However, courts have been split on this issue.

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[87] *The Health Care Directives Act*, CCSM, c H27 s 4.
[88] *The Health Care Directives and Substitute Health Care Decision Makers Act*, SS 2015, c H-O.002, s 3.
[89] *Medical Consent of Minors Act*, SNB 1976, c M6.1, ss 2-3.
[90] *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, s 4.
[91] *Care Consent Act*, SY 2003, c 21, Sch B, s 3.

C. Caselaw

In *AC v Manitoba (Director of Child and Family Services)*[92] a girl under the age of 16 needed a blood transfusion in order to avoid grave consequences to her health. However, the transfusion was rejected by the girl and her parents due to their religious beliefs.

The trial judge ruled that transfusions should take place until she reaches the age of 16. AC and her parents argued that the law violated their rights, including their freedom of religion under Section 2 of the *Charter*, their liberty and security of the person rights under Section 7, and their equality rights under Section 15.

The Supreme Court described the mature minor doctrine:

> … the common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. This is known as the common law "mature minor" doctrine. As the Manitoba Law Reform Commission noted, this doctrine is "a well-known, well-accepted and workable principle which . . . raise[s] few difficulties on a day-to-day basis" (*Minors' Consent to Health Care* (1995), Report #91, at p. 33). The doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal. [93]

The Supreme Court added:

> In some cases, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether, and the child's wishes will become the controlling factor. If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, the court is persuaded that the necessary level of maturity exists, it seems … necessarily to follow that the adolescent's views ought to be respected. Such an approach clarifies that in the context of medical treatment, young people under 16 should be permitted to attempt to demonstrate that their views about a particular

[92] *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 (CanLII), [2009] 2 SCR 181 [*AC v Manitoba*].
[93] *AC v Manitoba* at para 46.

> medical treatment decision reflect a sufficient degree of independence of thought and maturity.[94]

The majority of the Supreme Court held that there was no violation of sections 2, 7 and 15 of the *Charter*.

In *Pole v Region 2 Hospital Corporation*, the New Brunswick Court of Appeal held that at common law a mature minor has the "legal capacity to consent to his or her own treatment," including "the right to refuse treatment." [95]

The Court stated that at common law a mature minor "is able to take care of themselves" and may make decisions about medical treatment.[96] The Court added that for persons under 16, the New Brunswick *Medical Consent of Minors Act* modified the common law so that:

> in addition to the informed consent of the mature minor, there must also be opinions from two medically qualified practitioners that the minor is capable of understanding the nature and consequences of the treatment and that such treatment is in the best interests of the minor and his continuing health and well-being.[97]

In *Re LDK*[98], a 12-year-old girl was suffering from acute myeloid leukaemia and needed blood transfusions. She and her parents were Jehovah's Witnesses and refused the chemotherapy treatment which required blood transfusions. The Children's Aid Society apprehended the girl to ensure she received the treatment. Two doctors testified that the treatment was intensive and aggressive and that the rate of cure after treatment was 30 percent.[99]

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[94] *AC v Manitoba* at para 87.
[95] *Pole v Region 2 Hospital Corporation*, 1994 CanLII 4470 (NB CA) at pp 17-18 [*Pole v Region*].
[96] *Pole v Region* at p 15.
[97] *Pole v Region* at pp 15-16.
[98] *Re LDK (An Infant)*, 1985 CanLII 2907 (ON CJ) [*Re LDK*].
[99] *Re LDK* at paras 13-14.

The judge found that "the emotional trauma that she would experience as a result of any attempt at transfusion could have nothing but a negative effect on any treatment being undertaken."[100] He concluded that: "this child's life is equally in danger whichever path is taken, whether she is left here [in hospital] and subjected to this treatment or she is allowed to leave and be treated according to the wishes and beliefs of herself and her parents."[101]

Finally, the judge considered the girl's religious beliefs against any blood transfusion and decided that "upon being given a blood transfusion, her right to the security of her person pursuant to section 7 was infringed."[102]

In *Alberta (Director of Child Welfare) v H (B)*,[103] a 16-year-old girl was diagnosed with acute myeloid leukemia. The recommended treatment was intense chemotherapy, which would require the use of blood transfusions. The treatment had a success rate of 40-50 percent, which increased to 50-65 percent if accompanied by a bone marrow transplant.[104]

The girl and her parents, Jehovah's Witnesses, rejected any blood transfusion. The father later changed his mind and consented, but the hospital and physicians refused to treat the girl without her consent as they thought she was mature enough to refuse the treatment.

However, the Provincial Court Judge found that the girl was not mature enough to make the decision to die.[105]

The Judge stated:

> I find that BH has not had the life or developmental experience which would allow her to question her faith and/or its teachings and that such experience is an essential step in arriving at a personal level of development such that she can be considered to be a mature minor who has the capacity to refuse medical treatment

[100] *Re LDK* at para 19.
[101] *Re LDK* at para 27.
[102] *Re LDK* at paras 32-33.
[103] *Alberta (Director of Child Welfare) v H (B)*, 2002 ABPC 39 (CanLII) [*Alberta v H (B)*]
[104] *Alberta v H (B)*) at para 3.
[105] *Alberta v H (B)*) at para 19.

> which is necessary to save her life. Intelligence, thoughtfulness, exemplary behaviour and notable academic achievement are not sufficient when the magnitude of the decision faced by a 16-year-old involves a certain risk of death.[106]

VI. Medical Treatment and Young Children in Canada

Young children are innocent and vulnerable. They cannot decide for themselves until they reach a certain level of maturity. They need care, protection, direction and nourishment and medical health care.[107]

Parents or guardians are in the best position to take care of their children. Therefore, when children do not have the capacity to accept or refuse medical treatment, parents or guardians have to decide on their behalf by taking into consideration the best interests of the child.[108]

A. Parents and Best Interests of the Child

As mentioned above, in Canada, parents generally have primary decision-making rights for a child up to the age of 16. Since children are vulnerable, decisions made on their behalf must protect their well-being.

Parents have legal and moral obligations towards their children. They are required to decide on their children's care, education and medical treatment, etc. However, parents' rights are not

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[106] *Alberta v H (B)* at para 25.
[107] David C. Day at 380.
[108] Shawn HE Harmon, David E Faour & Noni E MacDonald, "Physician Dismissal of Vaccine Refusers: A Legal and Ethical Analysis", online: McGill Journal of Law and Health, 2020 CanLIIDocs 550 <https://www.canlii.org/en/commentary/doc/2020CanLIIDocs550#!fragment/zoupio-_Tocpdf_bk_1/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoAvbRABwEtsBaAfX2zhoBMAzZgI1TMAjAEoANMmylCEAIqJCuAJ7QA5KrERCYXAnmKV6zdt0gAynlIAhFQCUAogBl7ANQCCAOQDC9saTB8aqoiIkA> at 268 [Shawn HE Harmon].

absolute, meaning that they cannot make decisions on medical treatment according to their own interests instead of in the interests of the child.[109]

Parents and guardians can either accept or reject a medical treatment for their child, but their decisions must prioritize the child's best interests.

Amy Mullin stated:

> custodial parents have rights to make decisions about their children's welfare, but these rights are based on parental responsibilities. These responsibilities crucially include both an obligation to make decisions motivated by loving care for the child (and hence what parents believe will advance their children's interests) and an obligation to be reasonable in their judgments about children's well-being and development – and diligent in working to secure children's interests.[110]

In General Comment No.14 on the right of the child to have his or her best interests taken as a primary consideration, the Committee on the Rights of the Child stated:

> … Children have less possibility than adults to make a strong case for their own interests, so those involved in decisions affecting a child must be explicitly aware of the child's interests. If the interests are not highlighted, they tend to be overlooked.[111]

Article 3(1) of the *Convention on the Rights of the Child* states:

> All actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. [112]

When making a decision on medical treatment for a child, judges need to make their decisions based on the best interests of the child.

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[109] Shawn HE Harmon at 269.
[110] Impact Ethics, "Aboriginal Rights and the Welfare of First Nations Children" (20 November 2014), online: <https://impactethics.ca/2014/11/20/aboriginal-rights-and-the-welfare-of-first-nations-children/>.
[111] Committee on the Rights of the Child, *General Comment No. 14 (2013) on the Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration (Art. 3, Para. 1)*, United Nations Convention on the Rights of the Child, online: Refworld https://www.refworld.org/docid/51a84b5e4.html at para 37.
[112] *Convention Rights of the Child*.

In *E (Mrs.) v Eve*, the Supreme Court discussed the "best interests" test:

> Under the present state of the law, the only guideline available to circuit courts faced with this problem appears to be the "best interests" of the person to be sterilized. This is a test that has been used for a number of years in this jurisdiction and elsewhere in the determination of the custody of children and their placement--in some circumstances placement in a controlled environment ... No one who has dealt with this standard has expressed complete satisfaction with it. It is not an objective test, and it is not intended to be. The substantial workability of the test rests upon the informed fact-finding and the wise exercise of discretion by trial courts engendered by long experience with the standard. Importantly, however, most determinations made in the best interests of a child or of an incompetent person are not irreversible; and although a wrong decision may be damaging indeed, there is an opportunity for a certain amount of empiricism in the correction of errors of discretion. Errors of judgment or revisions of decisions by courts and social workers can, in part at least, be rectified when new facts or second thoughts prevail. And, of course, alleged errors of discretion in exercising the "best interest" standard are subject to appellate review.[113]

In *B (R) v Children's Aid Society of Metropolitan Toronto,*[114] the Supreme Court decided on a case where Jehovah's Witnesses parents refused a blood transfusion for their newborn daughter.

The parents argued that according to section 7 of the *Charter*, they had the right to decide on medical treatment for their daughter. They also argued that section 2 of the *Charter* allowed them to do so in accordance with their religious beliefs.

The Supreme Court ruled against the parents and permitted the blood transfusion to take place. The Supreme Court stated that "parental duties are to be discharged according to the best interests of the child."[115] The Court added that "the exercise of parental beliefs that grossly invades those best interests is not activity protected by the right to liberty in section 7. There is

[113] *E (Mrs.) v Eve*, 1986 CanLII 36 (SCC), [1986] 2 SCR 388 at para 89 [*E (Mrs.) v Eve*].
[114] *B (R) v Children's Aid Society of Metropolitan Toronto*, 1995 CanLII 115 (SCC), [1995] 1 SCR 315 [*B (R) v Children's Aid Society*].
[115] *B (R) v Children's Aid Society* at p 320.

simply no room within section 7 for parents to override the child's right to life and security of the person."[116]

Although the law gives parents and guardians the responsibility to raise their children, sometimes their religious and social beliefs may conflict with the "best interests" of the child. It is at this point where the government can intervene on behalf of the child.

B. Parens Patriae

The parens patriae jurisdiction is based on the concept that those who are incapable of caring for themselves, need to be protected (e.g. children, mentally ill persons, etc.). Courts have ruled that this protection must be decided upon in the best interest of these individuals.[117]

In Latin, parens patriae means parent of the country. It is a "doctrine that grants the inherent power and authority of the state to protect persons who are legally unable to act on their own behalf."[118]

This doctrine first started with the protection of mentally ill people, not the health of children. [119] When parents or guardians are unable to meet their child's needs, the state must intervene on behalf of the children and mentally incapable people under the parens patriae jurisdiction.[120]

In *E (Mrs.) v Eve* (mentioned earlier), the Supreme Court stated:

> …in the case of idiots, mentally incompetent persons or persons of unsound mind, and their property and estate, the jurisdiction of the Court shall include that which in England was conferred upon the Lord Chancellor by a Commission from the Crown under the Sign Manual, except so far as the same are altered or enlarged as aforesaid.[121]

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[116] *B (R) v Children's Aid Society* at p 320.
[117] Legal Representation of Children in Canada, online: Department of Justice <https://www.justice.gc.ca/eng/rp-pr/other-autre/lrc-rje/p3.html>.
[118] *JRank Legal Encyclopedia*, "Parens Patriae", online: <https://law.jrank.org/pages/9014/Parens-Patriae.html>.
[119] David C. Day at 398.
[120] David C. Day at 380.
[121] *E (Mrs.) v Eve* at para 39.

The Supreme Court added:

> Despite this vagueness, however, it seems clear that the *parens patriae* jurisdiction was never limited solely to the management and care of the estate of a mentally retarded or defective person. As early as 1603, Sir Edward Coke in *Beverley's Case*, 4 Co. Rep. 123 b, at pp. 126 a, 126 b, 76 E.R. 1118, at p. 1124, stated that "in the case of an idiot or fool natural, for whom there is no expectation, but that he, during his life, will remain without discretion and use of reason, the law has given the custody of him, and all that he has, to the King.[122]

In *B (R) v Children's Aid Society of Metropolitan Toronto* (also mentioned above), the Supreme Court noted that the Courts have shown reluctance to interfere with parental rights, and that state interference is tolerated only when necessity has been demonstrated.[123]

In *Wagner v. Melton*, the Supreme Court of the Northwest Territories explained that before exercising its *parens patriae* jurisdiction to appoint legal counsel for a child, courts must see if doing so would be in the best interests of the child and whether the child is capable of providing instructions to a lawyer:

> A number of guiding principles have emerged from cases where courts have been asked to use their parens patriae jurisdiction to appoint counsel for a child in custody and access proceedings.
>
> First, the most important question is whether or not appointing counsel to represent a child is in that child's best interest.
>
> Second, the court must be satisfied that the child can provide instructions to a lawyer. If the child cannot do so, then counsel should not be appointed and other methods of ascertaining the child's views must be explored.
>
> Third, it should be exercised sparingly and only where the adult litigants cannot adequately represent the child's views to the court. L.M.H.; Smith, supra. I agree with the comments of Germaine, J., in L.M. H. that in custody and access disputes, ". . . the presumption should be against this type of appointment."[124]

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[122] *E (Mrs.) v Eve* at para 40.
[123] *B (R) v Children's Aid Society* at p 371.
[124] *Wagner v Melton*, 2012 NWTSC 41 (CanLII) at paras 5-8.

Governments have a duty to intervene sometimes to protect young children, but does that apply to vaccinations?

VII. Vaccinations in Canada

Vaccines are one of the most important health interventions of the 20th century. Most "vaccine-suppressed infectious diseases" are provided in certain geographical areas in order to stop the transmission of the disease.[125] The problem that public health authorities face is that when outbreaks happen scarcely, parents of young children start questioning the necessity of vaccination and this can lead to vaccine rejection by them.

A. Definition

According to the WHO, vaccination is "a simple, safe, and effective way of protecting people against harmful diseases, before they come into contact with them. It uses your body's natural defenses to build resistance to specific infections and makes your immune system stronger."[126]

Also, according to the WHO organization "immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease."[127]

[125] Shawn HE Harmon at 255.
[126] Vaccines and Immunization: What is Vaccination?, online: World Health Organization <https://www.who.int/news-room/q-a-detail/vaccines-and-immunization-what-is-vaccination> [Vaccines and Immunization].
[127] Vaccines and Immunization.

However, despite the strong evidence that vaccinations are safe and effective in preventing serious infectious diseases, many parents still refuse, for different reasons, to immunize their children.

B. The Rights of Parents to Refuse Vaccinations for Their Children

In Canada, vaccines are approved and licensed by the Bureau of Biologics and Radiopharmaceuticals of the Health Protection Branch, Health Canada where they continue to be observed after approval. Adverse events after immunization are monitored by the Canadian Adverse Events Following Immunization Surveillance System (CAEFISS).[128]

Vaccines are not mandatory in Canada, but most parents immunize their children. However, some parents are reluctant to vaccinate their children for different reasons. It is important to note here that some children can be allergic to vaccines and cannot be vaccinated.[129]

Surveys have showed that those who reject vaccinations are usually concerned about the risks associated with the vaccines. The Ipsos poll found that two-thirds (64 per cent) of Canadians worry about the side effects of vaccinations.[130]

According to Dr. Shelley Deeks, who is against mandatory vaccines "it should … be about understanding why people are choosing not to vaccinate, because we really do need to do a better

[128] Law Reform Commission of Saskatchewan, Consultation paper: Vaccination and the Law (September 2007), 2007 CanLIIDocs 223, online: CanLII <https://www.canlii.org/en/commentary/doc/2007CanLIIDocs223?zoupio-debug=#!fragment/zoupio-_Toc3Page3/(hash:(chunk:(anchorText:zoupio-_Toc3Page3),notesQuery:'',scrollChunk:!n,searchQuery:'vaccinations%20and%20children',searchSortBy:RELEVANCE,tab:toc))> at 5.
[129] Noni MacDonald, Shalini Desai & Betty Gerstein, "Working With Vaccine-Hesitant Parents: An Update" (14 September 2018), online: Canadian Paediatric Society < https://www.cps.ca/en/documents/position/working-with-vaccine-hesitant-parents>.
[130] Jeff Semple, "Unvaccinated: Should Vaccinations be Mandatory for School-Aged Kids?" (3 April 2019), online: Global News < https://globalnews.ca/news/5125086/mandatory-vaccination-kids-canada-poll/> [Jeff Semple].

job of understanding that. And then addressing their concerns and assisting them with the right choice."[131]

In Canada, several provinces require children to be vaccinated in order to attend school.[132] Ontario and New Brunswick legislation requires school children to be vaccinated against "diseases like diphtheria, tetanus, polio, pertussis (whooping cough), measles, rubella, mumps, varicella (chicken pox) and meningococcal disease."[133] In British Columbia, parents are encouraged, but not required to vaccinate their children. If a parent chooses to not have their child vaccinated, they will be asked to sign a form, and, if there is an outbreak of a vaccine-preventable disease at school, the child may be asked to stay home until it is safe to return.[134]

Across the different provinces, there are different exemptions for children who do not get vaccinated for "medical, religious and ideological reasons."[135] "To opt out, parents must sign and notarize an affidavit with a statement of these beliefs. Statements of medical exemptions must be provided to schools by a physician or nurse practitioner."[136] However, in the event of a disease outbreak, unvaccinated children can be prevented from going to school for public safety.

In Alberta, there is no legislation that mandates vaccinations for school enrollment, meaning parents do not have to immunize their children in order to enroll them in school. However, the government does have the authority to implement measures during disease outbreaks, including

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[131] Jeff Semple.
[132] Mariette Brennan, Kumanan Wilson & Vanessa Gruben Mandatory, "Childhood Immunization Programs: Is There Still A Role For Religious And Conscience Belief Exemptions?" (2021) 58 :3 online: Alberta Law Review <https://albertalawreview.com/index.php/ALR/article/view/2643>.
[133] Erin Walkinshaw, "Mandatory Vaccinations: The Canadian Picture" (8 November 2011), online: CMAJ < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216452/>.
[134]Government of British Columbia, "Vaccine Status Reporting Regulation", *ImmunizeBC*, online: <https://immunizebc.ca/children/vaccine-status-reporting-regulation>.
[135] Karen Born, Verna Yiu & Terrence Sullivan, "Provinces Divided Over Mandatory Vaccination for School Children" (22 May 2014), online: < https://healthydebate.ca/2014/05/topic/health-promotion-disease-prevention/mandatory-school-entry-vaccinations> [Karen Born].
[136] Karen Born.

restricting unvaccinated children from attending school in order to prevent the spread of infectious diseases.[137]

Judy MacDonald, former Calgary's Medical Officer of Health with Alberta Health Services stated that "Alberta has no legislation in place to mandate that children show proof of vaccination to enter school".[138] She added that "the province's Public Health Act requires that in an outbreak, the Medical Officer of Health must exclude children at schools if they have not received the measles vaccine."[139]

It should be noted however, that following the introduction of the *Public Health Amendment Act*[140] in 2023, significant changes were made to Alberta's *Public Health Act*, particularly regarding the roles and responsibilities of cabinet and medical officers of health during declared public health emergencies. Notably, the act grants cabinet the authority to make final decisions on public health orders affecting all persons or groups, including those in educational settings, during such emergencies.

C. Caselaw

When it comes to children's vaccination, courts have intervened under the jurisdiction of parens patriae and ordered vaccines be administered despite the refusal of a parent.

In *Chmiliar v Chmiliar*, [141] the mother who was the custodial parent refused to vaccinate her children despite a meningitis outbreak, while the father wanted them to be vaccinated. The Alberta Court of Queen's Bench ordered that the 10-year-old son be vaccinated. The Court found

[137] Eva Ferguson, "Alberta Won't Follow Other Provinces' Proactive Approach on Immunization" (4 July 2019), online: Calgary Herald < https://calgaryherald.com/news/local-news/alberta-wont-follow-other-provinces-proactive-approach-on-immunization>.
[138] Karen Born.
[139] Karen Born.
[140] *Public Health Amendment Act*, 2023, SA 2023, c 11.
[141] *Chmiliar v Chmiliar*, 2001 ABQB 525 (CanLII) at para 31 [*Chmiliar v Chmiliar*].

that the 13-year-old daughter had been so influenced by her mother's irrational fears that she had lost her capacity to make a rational decision in relation to vaccination.[142]

The Court concluded by stating the following:

> The vaccinations involved are not required for life or death at this time. Therefore, given that the daughter is so fearful of the consequences of the vaccine, I will not order the vaccinations because on balance, her fear outweighs the benefits at this time. She will be sixteen in three years and has said that she will undertake the rubella vaccine. I am hopeful that she will do so to protect her children. Further, as she matures, I am hopeful that she will come to her own conclusions about her healthcare in a balanced way, not tainted by irrational fear.[143]

In *MJT v DMD* [144] both parents shared decision-making authority regarding their child's welfare. The mother did not permit the child to receive any vaccinations, contrary to the father's will.

The Supreme Court of British Columbia decided that "the benefits of immunization to the child significantly outweigh any risk of side effects. The Court also concluded that the father, who wanted the child to be vaccinated, was entitled to make the decision concerning the child's immunization."[145]

In *CMG v DWS,*[146] the parents were divorced and had decided not to vaccinate their daughter so she can decide for herself when she is 12 years old. When the daughter turned ten, the custodial mother wanted to take her on a trip to Germany. The father asked that the daughter be vaccinated.

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[142] *Chmiliar v Chmiliar* at para 61.
[143] *Chmiliar v Chmiliar* para 65.
[144] *MJT v DMD* 2012 BCSC 863 (CanLII) [*MJT v DMD*].
[145] *MJT v DMD* at para 176.
[146] *CMG v DWS*, 2015 ONSC 2201 (CanLII) [*CMG v DWS*].

The Court decided that:

> […] there is sufficient evidence on the balance of probabilities that the child in this case should be vaccinated in her best interests. Public policy as expressed by the Ontario and Canadian governments supports vaccinations as essential to the health of children and the public in general. The World Health Organization promotes vaccinations for the same purposes as a matter of public health and safety.[147]
> …
> As a result of the above reasons, there shall be an order that the father shall have the decision-making ability with respect to the child getting vaccinations. Prior to the child being taken on the trip to Germany, she shall receive a vaccination for measles, mumps, and rubella or whatever vaccination combination for these diseases is recommended by the child's family doctor.[148]

As a result, the Court ordered the mother not to communicate with the child in a manner that would be negative to the child receiving the vaccinations.[149]

In October 2019, the non-profit organization Vaccine Choice Canada and five Ontario mothers filed a lawsuit against the government, alleging the *Immunization of School Pupils Act*[150] violated different constitutional rights including freedom of conscience and religion and to liberty and security of the person.[151] As of now, no decision has been made, and there has been no further updates regarding the progression of the lawsuit.

[147] *CMG v DWS* at para 105.
[148] *CMG v DWS* at para 107.
[149] *CMG v DWS* at para 108.
[150] *Immunization of School Pupils Act,* RSO 1990, c I.1

[151] Shawn Jeffords, "Court Challenge of Ontario's Vaccination Law Unlikely to Succeed: Experts" (29 October 2019), online: National Post < https://nationalpost.com/pmn/news-pmn/canada-news-pmn/group-behind-legal-challenge-to-child-vaccination-scheme-to-hold-rally-in-toronto >.

VIII. Section 215 of the Canadian Criminal Code

The Canadian *Criminal Code* contains general criminal offenses, such as assault and homicide, that apply to violent acts against children. The *Code* also contains child-specific offenses such as the failure to provide life necessities, child abandonment, and others.

A. Failure to Provide the Necessaries of Life

Necessaries of life include food, clothing, shelter and care needed to stay alive and be healthy. There is a duty, under section 215 of the *Criminal Code*, to provide these necessaries to people to whom we owe a duty.

Section 215(1) of the *Criminal Code* reads:

> Everyone is under a legal duty
> **(a)** as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
> …
> **(c)** to provide necessaries of life to a person under his charge if that person
> **(i)** is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
> **(ii)** is unable to provide himself with necessaries of life.

Section 215(1)(a) talks about the duty that parents and guardians owe to children younger than 16. Section 215(1)(c) mentions a duty that someone owes to those who are under their care, who by reason of detention, age, illness, mental disorder or other cause, are unable to withdraw from their care and are unable to provide themselves with the necessaries of life. Section 215(1)(c) applies to dependent children, spouses, prisoners in detention, disabled, old people and other vulnerable people who need care and are under the care of another.[152]

[152] Gail Wartman, "Neglect can lead to criminal charges" (14 March 2014), online: The Western Producer < https://www.producer.com/farmliving/neglect-can-lead-to-criminal-charges/> [Gail Wartman].

Section 215(2) states:

> Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if (a) with respect to a duty imposed by paragraph (1)(a) or (b), (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Under section 215(2), an offence occurs when a person to whom we owe that duty is found to be in destitute or disadvantaged situations or in cases where their life is threatened, or their health is likely to be endangered permanently.

Section 215(3) states:

> Everyone who commits an offence under subsection (2) is guilty of
> (*a*) an indictable offence and is liable to imprisonment for a term not exceeding two years; or
> (*b*) an offence punishable on summary conviction.

Section 215 of the *Criminal Code* establishes a uniform standard of care that must be provided to certain individuals, setting a societal benchmark rather than a personal one. The "necessaries of life" referred to in the section are those essentials for preserving life, rather than the usual legal definition of necessaries. Failure to seek medical attention may also constitute a failure to provide the necessaries of life. Finally, when determining whether there is a duty to act, factors such as the severity of the injury and the awareness of its occurrence must be considered.[153]

[153] Canadian Criminal Law/Offences/Failing to Provide the Necessities of Life, online: Wikibooks <https://en.wikibooks.org/wiki/Canadian_Criminal_Law/Offences/Failing_to_Provide_the_Necessities_of_Life> [Necessities of Life].

Where a duty is found, the crown must prove:

> the accused acts or omissions which led to the failure to provide necessaries of life were a marked departure from the conduct of a reasonably prudent person in similar circumstances, and
>
> it was objectively foreseeable that the failure to provide necessaries would lead to a risk of danger to the life or permanent endangerment to the health of the person to whom the duty is owed.[154]

The term "endangers" refers to exposing someone to danger, harm, or risk, but does not necessarily imply actual injury or damage.[155]

Under section 215, the accused must show that there was a lawful excuse not to provide the necessaries of life when the person to whom they owe the duty is found to be in the circumstances mentioned above.

The crown has to prove that a "marked departure from the conduct of a reasonably prudent person" took place as it was foreseeable that the failure to provide the necessaries of life would put somebody in danger. [156]

B. Caselaw

There are many cases where parents have been convicted under section 215 for failure to provide their child with the necessaries of life, particularly for failure to provide suitable medical attention.

In 1902, the Supreme Court of British Columbia stated in *The King v Brooks* that "the terms "necessaries of life," and "necessaries," … mean … such necessaries as tend to preserve life, and not necessaries in their ordinary legal sense."[157]

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[154] Necessities of Life.
[155] Necessities of Life.
[156] Gail Wartman.
[157] *The King v Brooks*, 1902 CanLII 90 (BC SC) at p 378.

In *R v SJ*,[158] the parents of a 3-year-old child were convicted of failing to provide the necessaries of life to their child who was in necessitous circumstances.

In this case, the Court of Appeal for Ontario cited *The King v Brooks* and other cases to define necessaries of life:

> The scope of the term "necessaries of life" has been considered several times in the case law. As far back as 1902, in *R v Brooks* (1902), 1902 CanLII 90 (BC SC), 9 BCR 13, at p 18, the British Columbia Court of Appeal held that "necessaries of life" meant such necessaries as tended to preserve life. In 1912, in *R v Sidney* (1912), 21 WLR 853, at p 857-858, the Saskatchewan Supreme Court confirmed the holding in *Brooks*, noting that necessaries of life had been held to include "food, clothing, shelter, and medical attendance" and observed that this was not an exhaustive test. Further, necessaries of life are to be determined on a case by case basis. Other cases touching on the ambit of necessaries of life include: *R v Hariczuk*, [1999] OJ No 1424 (Ont CJ); *R v Morris* (1981), 1981 CanLII 1216 (AB QB), 61 CCC (2d) 163 (Alta QB); *R v Pertab* (2004), 2004 CanLII 47791 (ON SC), 27 CR (6th) 126 (Ont SC); and *R v Popen* (1981), 1981 CanLII 3345 (ON CA), 60 CCC (2d) 232 (Ont CA). In this last decision, Martin JA wrote,at p. 240:
> We are disposed to think that the words "necessaries of life" in section 197 [now s. 215] may be wide enough to include not only food, shelter, care, and medical attention necessary to sustain life, but also necessary protection of a child from harm.[159]

In order to be acquitted, parents are required to meet the standard of conduct of a reasonably prudent parent. Their conduct should not be a "marked departure" from the norm.

In *R v Naglik*,[160] the mother and her common law husband were charged with aggravated assault of, and failure to provide necessaries of life to, their infant son. The child was brought to the hospital after enduring significant injuries which had caused permanent damage.

The Supreme Court stated:

> … the offence in question requires actual knowledge of (which would include wilful blindness with respect to) the circumstances which make the failure to

[158] *R v S.J.*, 2015 ONCA 97 (CanLII) [*R v S.J.*].
[159] *R v S.J.* at para 50.
[160] *R v Naglik*, 1993 CanLII 64 (SCC), [1993] 3 SCR 122 [*R v Naglik*].

> perform the duty to provide necessaries an offence. It is an offence which may be committed intentionally or recklessly. It is not an offence of mere negligence, where an honest belief in circumstances which do not require the performance of the duty must be based on reasonable grounds.[161]

The Supreme Court added:

> Section 215(2)(*a*)(ii) makes the failure to fulfil the duty to provide necessaries an offence where "the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently". It thus punishes a marked departure from the conduct of a reasonably prudent parent in circumstances where it was objectively foreseeable that the failure to provide the necessaries of life would lead to a risk of danger to the life, or a risk of permanent endangerment to the health, of the child. The Crown must prove beyond a reasonable doubt both that the circumstances listed in subs. (2)(*a*)(ii) were objectively foreseeable in the circumstances, and that the conduct of the accused represented a marked departure from the standard of care required by those circumstances.[162]

Moreover, in *R v Tutton*, [163] the parents were convicted of manslaughter for denying the necessaries of life to their child based on their religious convictions. The parents, who believed in faith healing, refused to allow their diabetic child to receive insulin injections.

The Supreme Court ordered a retrial and ruled that:

> the assertion of the Tuttons that they believed a cure had been effected by Divine intervention and that insulin was not necessary for the preservation of the child's life would have to be considered by the jury. The jury would have to consider whether such belief was honest and whether it was reasonable.[164]

Also, the Court decided that "the jury would be required to decide whether the refusal of insulin and medical attention represented a marked and significant departure from the standard to be observed by reasonably prudent parents."[165]

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[161] *R v Naglik.*
[162] *R v Naglik*.
[163] *R v Tutton*, 1989 CanLII 103 (SCC), [1989] 1 SCR 1392 [*R v Tutton*].
[164] *R v Tutton*.
[165] *R v Tutton*.

However, in *R v Brennan*,[166] the Provincial Court Judge acquitted the mother of failing to provide the necessaries of life to her two-month-old child. The baby was born premature but gained weight and grew while in the hospital. However, once in the mother's care, the child started losing weight, despite visits from a public health nurse who counseled the mother and provided a feeding regimen for her to follow.

The Provincial Court Judge found that:

> … the accused's feeding regime and practices and procedures she employed were not sufficient to adequately sustain this child as the baby was required to be hospitalized. She failed to adequately feed the baby. However …, this was not apparent to the accused nor would it have been to a reasonably prudent parent. While the weight gain or lack thereof was a continuing concern for the public health nurse, she never expressed any serious concerns to the accused.
>
> While it is possible or even likely that a reasonable person, in these circumstances, may have been more attuned to the inadequacies of the feeding regime and employed more aggressive measures, particularly regarding the supplementary feeding, I cannot conclude beyond a reasonable doubt that the accused's actions were a marked departure from what a reasonable prudent parent might do in the circumstances.[167]

In a recent series of cases, *R v Stephan*, the parents were accused of refusing to provide medical care to their sick young boy until it was too late. When the child got sick, his parents consulted a family friend who was a nurse. They did not take him to a doctor, instead they gave him natural supplements, consulted a naturopathic clinic and called 911 when he stopped breathing.

[166] *R v Brennan*, 2006 NSPC 11 (CanLII) [*R v Brennan*].
[167] *R v Brennan* at paras 64-65.

The Stephans were charged under section 215(1) for failing to provide the necessaries of life. In 2016, the Court of Queen's Bench[168] found them guilty and their appeal was dismissed by the Alberta Court of Appeal[169] in 2017.

In 2018, the Supreme Court allowed the Stephans' appeal and quashed their convictions and ordered a new trial.[170] The Supreme Court agreed that "the learned trial judge conflated the *actus reus* and *mens rea* of the offence and did not sufficiently explain the concept of marked departure in a way that the jury could understand and apply it."[171]

In the 2019 new trial, the Court of Queen's Bench[172] acquitted the Stephans but the Crown appealed the decision. In March 2021 the Alberta Court of Appeal[173] overturned the acquittal and ordered a new trial. Following that decision, the crown stayed the charges against the Stephans, but the Supreme Court had already been asked to grant leave to appeal the decision on a third trial.[174]

The Supreme Court declined to hear the appeal, effectively leaving the legal outcome unresolved. While the Stephans' lawyer expressed disappointment and concern about the broader implications for other parents in similar situations, the Alberta Crown Prosecution Service stated that the available evidence had deteriorated over time, and that they no longer believed there was a reasonable likelihood of conviction.[175]

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[168] *R v Stephan*, 2016 ABQB 319 (CanLII).
[169] *R v Stephan*, 2017 ABCA 380 (CanLII).
[170] *R v Stephan*, 2018 SCC 21 (CanLII), [2018] 1 SCR 633 at para 3 [*R v Stephan* SCC].
[171] *R v Stephan* SCC at para 2.
[172] *R v Stephan*, 2019 ABQB 715 (CanLII).
[173] *R v Stephan*, 2021 ABCA 82 (CanLII)
[174] CBC News, "David and Collet Stephan lose latest appeal to Supreme Court in son's meningitis death" (19 August 2022), online: <https://www.cbc.ca/news/canada/calgary/david-collet-stephan-supreme-court-canada-alberta-1.6540977> [CBC News].
[175] CBC News.

This case is significant because it focused on the medical choices made by parents—rather than medical practitioners—and led to criminal conviction based on their decision. Although the case did not have a clear final outcome, the various decisions and discussions surrounding it raise important questions about what constitutes a marked departure and what factors should be considered when determining whether a conviction under section 215 is warranted. These discussions highlight the challenges in balancing parental autonomy and the legal duty to provide necessary care to children.

As Minister of Justice, Pierre Trudeau introduced the *Criminal Law Amendment Act* or *C-195*. Trudeau famously stated that "there's no place for the state in the bedrooms of the nation" And further emphasized that "what's done in private between adults doesn't concern the *Criminal Code*."[176]

This raises a critical question: If the state has no place in the private lives of individuals, why then should parents who choose complementary or alternative medicine for their children face conviction under the *Criminal Code*? This tension highlights the delicate balance between individual freedoms, parental rights, and the state's role in protecting vulnerable individuals, particularly children.

IX. Medical Treatment and Aboriginal Rights in Canada

Even in the 21st century, traditional medicine is still considered to be the main source of health for most people in rural areas in many parts of the world. According to the World Health Organization, "the majority of the populations of most countries were still relying primarily upon

[176] CBC Digital Archives, Trudeau: 'There's no place for the state in the bedrooms of the nation', online: < https://www.cbc.ca/player/play/video/1.4715835>.

indigenous or traditional forms of medicine for meeting everyday health care needs. In some countries as many as 80 to 90% of the population fall into this category."[177] People opt for traditional medicine because it represents their values and beliefs, it is effective and of course more affordable.[178]

A. International Recognition

In 2007, the UN General Assembly adopted the *Declaration on the Rights of Indigenous Peoples*[179] *(UNDRIP)*, a non-binding document which urged states to address the rights of Indigenous peoples. This Declaration marked a significant step as the first formal international agreement between states and Indigenous communities whose human rights had been violated.[180]

Article 24 of *UNDRIP* states:

> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right. [181]

The World Health Organization has acknowledged that traditional medicine is a way of preserving Indigenous medical knowledge. Similarly, the Truth and Reconciliation Commission of Canada has called upon "those who can effect change within the Canadian health-care system to recognize the value of Aboriginal health practices and use them in the treatment of Aboriginal

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[177] Raymond Obomsawin at 5.
[178] Raymond Obomsawin at 5.
[179] *United Nations Declaration on the Rights of Indigenous Peoples*, *Adopted by the United Nations General Assembly*, Res 61/295, UNGAOR, 61st Sess, UN Doc A/RES/61/295 (13 September 2007), online: United Nations < https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf> [*United Nations Declaration on the Rights of Indigenous Peoples*].
[180] Carolyn Stephens et al, "UN Declaration on the Rights of Indigenous Peoples" (24 November 2007), online: The Lancet < https://www.thelancet.com/article/S0140-6736(07)61742-5/fulltext>.
[181] *United Nations Declaration on the Rights of Indigenous Peoples.*

patients in collaboration with Aboriginal healers and Elders were requested by Aboriginal patients."[182]

B. In Canada

Section 35 of the *Constitution Act*[183] 1982 states:

> (1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.
> (2) In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.
> (3) For greater certainty, in subsection (1) "treaty rights" includes rights that now exist by way of land claims agreements or may be so acquired.
> (4) Notwithstanding any other provision of this Act, the aboriginal and treaty rights referred to in subsection (1) are guaranteed equally to male and female persons.

While section 35 acknowledges the rights of aboriginal peoples, it does not define them explicitly. Instead, these rights have been clarified and interpreted through various Supreme Court cases.

In 1973, the Supreme Court in *R v Calder*[184] acknowledged the existence of aboriginal title to land. Then in 1990, the Supreme Court in *R v Sparrow*, [185] ruled that the aboriginal right to fish had not been extinguished.

Aboriginal rights can incorporate "cultural, social, political, and economic rights including the right to land, as well as to fish, to hunt, to practice one's own culture, and to establish treaties."[186]

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[182] Complementary and Alternative Health Care and Natural Health Products Standards (December 2018), online: College & Association of Registered Nurses of Alberta <https://cnps.ca/wp-content/uploads/2020/03/complementary-and-alternative-health-care-and-natural-health-products.pdf > at 4.
[183] *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.
[184] *Calder et al. v Attorney-General of British Columbia*, 1973 CanLII 4 (SCC), [1973] SCR 313.
[185] *R v Sparrow*, [1990] 1 S.C.R. 1075.
[186] What is Section 35 of the Constitution Act?, online: indigenousfoundations < https://indigenousfoundations.arts.ubc.ca/constitution_act_1982_section_35/>.

When it comes to medicine, Indigenous peoples across Canada have traditionally used plants and natural products to cure illnesses where more than 400 different species of plants (as well as lichens, fungi and algae) have been used for this purpose. In Indigenous communities, there are experts in traditional medicine where their practice considers spiritual ways of healing along with physical outcomes.[187]

Provinces, including Ontario, British Columbia and Manitoba have set up Indigenous health and wellness centres to provide conventional medicine along with traditional medicine to Indigenous peoples. These centers offer "basic primary health care services and community programs for chronic diseases, prenatal and postnatal childcare, health care training and community capacity building."[188] They have also introduced some traditional services such as "ceremonies, consultations with traditional healers, talking circles and community feasts."[189] In order to deliver western along with traditional medicine, these centres hire a composition of "physicians, nurse-practitioners, elders, nutritionists, mental health educators and health promotion staff."[190]

In addition, Indigenous-led health initiatives have begun to be utilized, aiming to "address the health inequities that have arisen from complex historical and contemporary traumas faced by many Indigenous communities."[191] These Indigenous-led health care partnerships offer innovative models of interprofessional collaboration blending traditional and western medicine.[192]

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[187] Indigenous Peoples' Medicine in Canada, online: The Canadian Encyclopedia < https://www.thecanadianencyclopedia.ca/en/article/native-medicines>.
[188] Raymond Obomsawin at 16.
[189] Raymond Obomsawin at 16.
[190] Raymond Obomsawin at 16.
[191] Lindsay Allen et. al, *Indigenous-Led, Indigenous-Informed Care in Ontario: Report from the Indigenous Nurses and Allies Interest Group* (June 2021), online: https://chapters-igs.rnao.ca/system/files/2021-06/Indigenous-led.pdf. at E208-E209 [Lindsay Allen].
[192] Lindsay Allen at E208.

According to Redvers, Marianayagam and Blondin:

> Across Canada, some jurisdictions have begun to recognize the value and necessity of integrating traditional medicine into care for Indigenous patients. In Ontario, for example, several large, primarily non-Indigenous hospitals have made considerable progress on integrating traditional healing into mainstream services
> …
> these hospitals share several common features with respect to the integration of Indigenous medicine. All have full-time employed Indigenous Patient Navigators, and the majority of institutions have policies to guide the use and accessibility for smudging ceremonies. The policies also specifically outline the staff support and resources that are in place to carry out each ceremony. Furthermore, all the institutions have an Indigenous advisory council/board that provide support and direction to staff on culturally respectful, competent, safe, and holistic services that could be provided for Indigenous patients and their families.[193]

In addition, traditional medicine has been integrated, to a certain level, in some Health Canada programs through the First Nations and Inuit Health Branch. "For addiction treatment, the Mental Health program offers ceremonies such as sweat lodges. Also, the Aboriginal Diabetes Initiative supports communities to include traditional practices into their diabetes prevention programs."[194]

This integration of traditional medicine into current health care services can improve the quality of these services for Indigenous peoples and can maintain traditional ways of healing.

C. Caselaw

In 2014, Justice Gethin Edward ruled in *Hamilton Health Sciences Corp. v DH*[195] that the parents of an 11-year-old First Nations girl "JJ", had the right to use traditional medicine to treat her acute lymphoblastic leukemia.

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[193] Nicole Redvers, Justina Marianayagam & Be'sha Blondin, "Improving access to Indigenous medicine for patients in hospital-based settings: a challenge for health systems in northern Canada" (11 February 2019), online: International Journal of Circumpolar Health < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6493304/>.
[194] Raymond Obomsawin at 16.
[195] *Hamilton Health Sciences Corp. v D*.H., 2014 ONCJ 603 (CanLII) [*Hamilton Health Sciences Corp. v D*.H.].

JJ had started chemotherapy at McMaster Children's Hospital, but ten days later, her mother DH stopped the treatment. McMaster Children's Hospital requested the Brant Children's Aid Society (Brant CAS) to intervene on behalf of JJ. According to the Hospital, the treatment was 99% successful and removing JJ from treatment was medical neglect, therefore making JJ in need of protection. Brant CAS refused to intervene and decided that the child was not in need of protection. Consequently, McMaster Children's Hospital took the CAS to court.

Justice Edward stated:

> … DH had expressed her strong faith in her native culture and was discontinuing her daughter's chemotherapy treatment to pursue traditional medicine which she and her family believed would help to heal JJ.
>
> … The family are committed traditional longhouse believers who integrate their culture into their day-to-day living. In short, their longhouse adherence is who they are and their belief that traditional medicines work is an integral part of their life.[196]

Justice Edward, quoted Chief Justice Lamer in *R v Van der Peet*[197] which explained why aboriginal rights exist and that these rights are protected under section 35(1) of the *Constitution Act*:

> In my view, the doctrine of aboriginal rights exists, and is recognized and affirmed by s. 35(1), because of one simple fact: when Europeans arrived in North America, aboriginal peoples were already here, living in communities on the land, and participating in distinctive cultures, as they had done for centuries. It is this fact, and this fact above all others, which separates aboriginal peoples from all other minority groups in Canadian society and which mandates their special legal, and now constitutional status.[198]

Justice Edward concluded by saying:

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[196] *Hamilton Health Sciences Corp. v D.H.* at paras 58-59.
[197] *R v Van der Peet*, 1996 CanLII 216 (SCC), [1996] 2 SCR 507.
[198] *Hamilton Health Sciences Corp. v D.*H. at para 64.

> It is this court's conclusion, therefore, that DH's decision to pursue traditional medicine for her daughter JJ is her aboriginal right.[199]
>
> I cannot find that J.J. is a child in need of protection when her substitute decision-maker has chosen to exercise her constitutionally protected right to pursue their traditional medicine over the Applicant's stated course of treatment of chemotherapy.[200]

In the same year, a similar case arose involving 11-year-old Makayla Sault, who also discontinued her chemotherapy treatment at McMaster Children's hospital to pursue traditional Indigenous medicine. However, the Children's Aid Society decided not to intervene, and the case was never sent to court.[201]

Typically, courts prioritize the child's best interests in medical treatment decisions. However, the ruling in *Hamilton Health Sciences Corp. v DH* deviated from this approach, placing greater emphasis son aboriginal rights. This contrasted with cases involving Jehovah's Witnesses, where courts often overruled parental or mature minor decisions to refuse life-saving blood transfusions, prioritizing the child's best interests instead.

Commenting on the decision in *Hamilton Health Sciences Corp. v DH,* Cheryl Milne of the Asper Centre for Constitutional Rights at the University of Toronto stated that "there really haven't been court decisions like this relating to this kind of care that have favored aboriginal rights and traditional aboriginal medicine."[202]

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[199] *Hamilton Health Sciences Corp. v D*.H. at para 81.
[200] *Hamilton Health Sciences Corp. v D*.H. at para 83.
[201] Connie Walker, "First Nations Girl's Family Rejects Chemo, Hospital Goes to Court to Force Treatment" (1 October 2014), online: CBC News < https://www.cbc.ca/news/aboriginal/first-nations-girl-s-family-rejects-chemo-hospital-goes-to-court-to-force-treatment-1.2782928>.
[202] Red Deer Advocate, ″Family of aboriginal girl with cancer can opt for traditional medicine: Judge″ (14 November 2014), online: <https://www.reddeeradvocate.com/news/family-of-aboriginal-girl-with-cancer-can-opt-for-traditional-medicine-judge-7088379>.

It is also important to note that section 1 of the *Charter,* which allows infringement of a *Charter* right if it is justified, does not apply to aboriginal rights under section 35 of the *Constitution Act* as section 35 is outside the scope of the *Charter*.

X. Recommendations

The Alberta Civil Liberties Research Centre recommends the following:

A. CAM Regulation

1. CAM practice should be regulated nationwide across Canada. Once regulated, colleges in in each province and territory should have the authority to enforce these rules, with consequences for practitioners who violate them.

2. People may choose CAM for various reasons, such as lack of trust in their physicians, recommendations from friends or family, or concerns about the side effects of conventional treatments. As a result, CAM practice should be regulated.

3. CAM should be subject to regulation for the following reasons:

Regulated colleges will have the authority to monitor and oversee the practices of CAM practitioners. They will also be able to investigate any complaints against these practitioners, ensuring accountability. Specific reasons for regulation include:

   a. Unregulated practitioners may pose a risk of harm to their patients.

   b. Unregulated practitioners can make improper or false claims regarding the efficacy of their treatments.

   c. Unregulated practitioners may provide low-quality services at high costs.

   d. CAM practices can have potential side effects such as safety, interaction with medications or other therapies and treatments.

e. Parents should be able to choose CAM treatments for their children instead of conventional medicine without government or court intervention, or fear of being persecuted under section 215 of the *Criminal Code*.

4. CAM practitioners should receive education and training from accredited colleges or schools.

5. CAM practice should be included under the public health care system.

B. Integration of Traditional Medicine

1. Health Canada should collaborate with Indigenous partners to integrate traditional medicine into the existing health care system for Indigenous peoples.

2. Health Canada should ensure that new services offer both traditional and conventional medicine as part of an integrated approach.

3. Health Canada should formally acknowledge the importance and necessity of maintaining traditional medicine.

4. Indigenous institutions focused on traditional medicine should receive adequate funding from the federal government to support their work.

C. Parents and Medical Treatment for Children

1. Mature Minors should have the right to choose their medical treatment if they can understand the benefits, risks, and consequences of the treatment.

2. Parents should have the right to make medical treatment or vaccination decisions for their children based on their beliefs and values, if these decisions do not amount to negligence or abuse, as defined under the *Criminal Code*.

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