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Best Interests or Autonomy? Navigating Parenting Disputes Over Children's Treatment

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ABSTRACT

Family courts are struggling to resolve parenting disputes over children's treatment. These cases ask judges to decide such sensitive matters as whether a young person will be vaccinated against their wishes, granted access to gender-affirming healthcare, or forced into therapy. Parenting disputes over children's treatment implicate two distinct and potentially conflicting areas of law: family law and health law. Because family law and health law employ different legal standards and espouse different legal principles, the outcome in these cases may depend on which legal framework is applied. This article makes two contributions. First, it surveys recent family court decisions and suggests that courts are resolving parenting disputes over children's treatment in one of three ways: (1) applying health law rather than family law; (2) drawing on health law principles in applying family law; and, most commonly, (3) applying family law rather than health law. Second, I look to larger debates around children's welfare versus autonomy to make a case for how the apparent tension between family law and health law in these cases may be reconciled.

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RÉSUMÉ

Les tribunaux de la famille peinent à résoudre les différends familiaux concernant le traitement des enfants. Dans ces affaires, les juges sont amenés à trancher des questions sensibles, telles que la vaccination d'un jeune contre sa volonté, l'accès à des soins de santé affirmant son identité sexuelle ou le recours forcé à une thérapie. Les différends familiaux concernant le traitement des enfants touchent deux domaines juridiques distincts et potentiellement contradictoires : le droit de la famille et le droit de la santé. Comme le droit de la famille et le droit de la santé utilisent des normes juridiques différentes et défendent des principes juridiques différents, l'issue de ces affaires peut dépendre du cadre juridique appliqué. Cet article apporte deux contributions. Premièrement, il analyse les décisions récentes des tribunaux de la famille et propose que ceux-ci tranchent les différends familiaux touchant le traitement médical des enfants selon l'une de ces trois approches : (1) en faisant prévaloir le droit de la santé sur celui de la famille ; (2) en utilisant les principes du droit de la santé comme base d'interprétation du droit familial ; ou, le plus souvent, (3) en appliquant le droit de la famille plutôt que celui de la santé. Deuxièmement, je me penche sur les débats plus larges concernant le bien-être des enfants par rapport à leur autonomie afin d'expliquer comment la tension apparente entre le droit de la famille et le droit de la santé dans ces affaires peut être conciliée.

INTRODUCTION

SOME of the most contentious family law disputes concern children's healthcare. In recent years, separated parents have asked family courts to decide whether children will be vaccinated against COVID-19,[1] receive therapy for "parental alienation,"[2] access gender-affirming healthcare,[3] and share counselling records with a parent.[4] The "children" at the centre of these cases are often adolescents with their own views on treatment.

Parenting disputes over children's treatment engage two distinct and potentially conflicting areas of law.[5] Healthcare decision-making with respect to one's child is an incident of "decision-making responsibility" (formerly "custody"),[6] and parents who cannot agree on the allocation of responsibility may ask a court to decide. Such decisions are made according to the "best interests of the child," of which a child's "views and

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1 See *JN v CG*, 2023 ONCA 77 at para 1 [*JN* CA]; *OMS v EJS*, 2023 SKCA 8 at paras 8–9 [*OMS* CA]; *Sembaliuk v Sembaliuk*, 2022 ABQB 62 at para 4 [*Sembaliuk*]; *PR v SR*, 2022 PESC 7 at para 21 [*PR*]; *TK v JW*, 2022 BCPC at paras 1–2.

2 See *AAG v JLG*, 2022 ABQB 119 at para 1; *AM v CH*, 2019 ONCA 764 at paras 35, 46 [*AM*]; *Leelarantna v Leelarantna*, 2018 ONSC 5983 at para 35 [*Leelarantna*]. See also Claire Houston, "Case Comment: Undermining Children's Rights in *A.M. v. C.H.*" (2020) 38 Can Fam LQ 99 at 104 [Houston, "Case Comment"].

3 See *AB v CD*, 2020 BCCA 11 at paras 1–6; *NK v AH*, 2016 BCSC 744 at paras 2–3. See also Claire Houston, "Respecting and Protecting Transgender and Gender-Non-conforming Children in Family Courts" (2020) 33:1 Can J Fam L 103.

4 See *LS v BS*, 2022 ONSC 5796 at paras 6–8. For commentary on this case, see Ian Ross & Samantha Wisnicki, "Motions for Children's Counselling Records in Ontario: A Complex and Uneven Terrain" (2023) 42:2 Can Fam LQ 163 at 192–95. Parents have also asked courts to decide whether an adolescent should receive ADHD medication (see *Gegus v Bilodeau*, 2020 ONSC 2242 [*Gegus*]), and whether an adolescent should be evaluated for a learning disability (see *Ouellette v Uddin*, 2018 ONSC 4520).

5 This article focuses on parenting disputes in family court. It does not consider physician or state-initiated cases to compel treatment of a child or assess a child's capacity to consent to treatment. For academic commentary on these issues, see Part II.B.1.

6 The 2021 amendments to the *Divorce Act* replaced "custody" and "access" with "decision-making responsibility" and "parenting time" (see *An Act to amend the Divorce Act, the Family, the Family Orders and Agreements Enforcement Assistance Act and the Garnishment, Attachment and Pension Diversion Act and to make consequential amendments to another Act*, SC 2019, c 16, ss 1(1–2), 1(7), amending *Divorce Act*, RSC 1985, c 3 (2nd Supp) [*Divorce Act*]).

preferences" is one factor.[7] Health law also confers authority on parents, as substitute decision-makers, to make treatment decisions for children, unless the child is "capable" of consenting to treatment themselves.[8] As will be discussed later in this essay, while healthcare decisions made on behalf of *incapable* children must be made in their "best interests," *capable* children can generally decide what treatment is best for them.

In parenting disputes over children's treatment, the choice of legal framework matters. Because family law and health law espouse different principles, different frameworks can lead to different results. A court that adopts a family law framework may order treatment in the "best interests" of a child, even where the child refuses treatment. A court that appeals to health law principles, including autonomy, may respect a child's treatment wishes. The first approach harnesses the power of the state to mandate one parent's treatment preference; the second empowers the child—along with the parent who supports the child's treatment wishes—to decide.

Scholarship on the intersection of family law and health law is limited. Most academic treatment looks at child protection cases in which a child refuses life-saving treatment, typically on religious grounds.[9] While parenting disputes and child protection cases raise similar questions about the scope of children's rights, they are different. In child protection cases, the contest is between the child (or, more typically, the parents) and the

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7 *Divorce Act*, *supra* note 6, s 16(3)(e).

8 A capable child is one who has the capacity to make treatment decisions. See Constance Macintosh, "Decisionally Incapable Children and Medical Treatment Choices in Canada" in Imogen Goold, Cressida Auckland & Jonathan Herring, eds, *Medical Decision-Making on Behalf of Young Children: A Comparative Perspective* (Oxford, UK: Hart Publishing, 2020) 177 at 180.

9 See e.g. Shawn HE Harmon, "Body Blow: Mature Minors and the Supreme Court of Canada's Decision in *A.C. v. Manitoba*" (2010) 4:1 McGill JL & Health 83; Judith Mosoff, "'Why Not Tell It Like It Is?': The Example of *P.H. v Eastern Regional Integrated Health Authority*, A Minor in a Life-Threatening Context" (2012) 63 UNB LJ 238; Mary J Shariff, "The Mature Minor Patient and the Refusal of Treatment" in John C Irvine, Philip H Osborne & Mary J Shariff, eds, *Canadian Medical Law* (Toronto: Carswell, 2013) 521. There has also been discussion about cases in which parents refuse treatment for children. See e.g. Alison Braley-Rattai, "The Best Interests of the Child and the Limits of Parental Autonomy to Refuse Vaccination" (2021) 15:1 McGill JL & Health 65.

state, whereas parenting disputes pit parent against parent.[10] Moreover, the threshold for court intervention in child protection cases is harm or risk of harm to a child, whereas courts in parenting cases can render a decision in the "best interests" of a child at the request of one or both parents, without evidence of harm or risk.

This essay explores how family courts are resolving parenting disputes over children's treatment and makes a case for how these cases ought to be resolved. Part I sets out the legal framework governing parenting disputes over children's treatment. I explain how family law, health law, and child protection law operate together—and sometimes at odds—to govern consent to children's treatment. Part II surveys recent family court decisions. This survey suggests that family courts are struggling to determine which legal framework to adopt when resolving parenting disputes over children's treatment. I demonstrate that family courts generally take one of three approaches in these cases: first, applying health law rather than family law; second, drawing on health law principles in applying family law; and third—most commonly—applying family law rather than health law. Part III attempts to reconcile these two legal frameworks implicated in parenting disputes over children's treatment. Drawing on larger debates over children's welfare versus autonomy, I argue that family courts should apply health law in cases involving *capable* minors and draw on health law principles, including autonomy, when assessing "best interests" in cases involving *incapable* children.

I. LEGAL FRAMEWORK

Children's treatment decisions engage different areas of law. Family law, including statutes that govern parental decision-making responsibility, authorizes parents to make medical decisions for children and determines how this authority will be shared between parents. Family law is guided by the "best interests of the child." On the other hand, health law governs consent to treatment, detailing who may consent to treatment on their own or on another's behalf. Health law espouses fundamental principles of autonomy and bodily integrity. Finally, child protection law

10 I do not mean to suggest that the state is absent in parenting disputes—only that it is not a party. While both parenting cases and child protection cases are resolved according to a child's best interests, child protection matters must first consider the threshold issue of harm or risk of harm to the child.

authorizes state intervention in families to protect children. Child protection laws may authorize child protection agencies and courts to make treatment decisions on behalf of children.

A. Family Law

Parents are generally entitled to make treatment decisions for their children. Medical decision-making on behalf of one's child is an incident of "decision-making responsibility."[11] This right constrains the actions of other individuals. For example, a physician who fails to obtain parental consent to treat a child can potentially be liable in tort.[12] This right also protects parents from the state. In *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, a majority of the Supreme Court of Canada held that parents have a constitutionally protected liberty interest that includes "[t]he right to nurture a child, to care for its development, and to make decisions for it in fundamental matters such as medical care," all free from state interference.[13]

Family courts allocate decision-making responsibility between parents. Parents prima facie share decision-making responsibility over children.[14] If parents cannot agree on how to exercise decision-making responsibility, they may apply to a court for a parenting order.[15]

Parenting orders are made according to the "best interests" of the child. Family law statutes typically define a child as a person under the age of majority.[16] In determining a child's best interests, a court must consider "the child's views and preferences, giving due weight to the child's age and maturity, unless they cannot be ascertained."[17] This

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11 Formerly known as "custody." See *Young v Young*, [1993] 4 SCR 3 at 6, 1993 CanLII 34 (SCC).

12 See *Toews v Weisner*, [2001] BCJ No 30 at 206, 2001 BCSC 15 [*Toews*], where a nurse who administered a vaccine to a child without her parents' consent was ordered to pay the child damages for battery.

13 [1994] SCJ No 24 at 317, 1995 CanLII 115 (SCC) [*BR*].

14 See *Children's Law Reform Act*, RSO 1990, c C12, s 20.

15 See e.g. Government of Ontario, "Parenting Time, Decision-making Responsibility and Contact" (last modified 29 July 2025), online: <ontario.ca> [perma.cc/V3C5-EAFG].

16 See *Divorce Act*, *supra* note 6, s 2(1).

17 *Ibid*, s 16(3)(e).

means that a court can make a parenting order in the best interests of any child under the age of eighteen—even an older child—irrespective of the child's views and preferences.[18]

Family courts make treatment decisions on behalf of children directly or indirectly. Where parents share decision-making responsibility but cannot agree on treatment, a court may order that treatment does or does not occur. Alternatively, a court may award medical decision-making authority to one parent to ensure that the treatment decisions of that parent will be followed.[19]

B. Health Law

Health law also grants parents the right to make treatment decisions on behalf of a child, *unless the child is capable of deciding for themselves.* Health law explicitly recognizes that there may be a point even before the age of eighteen when it is appropriate to transfer medical decision-making from a parent to a child. Depending on the jurisdiction, "mature minors," as they are referred to in the jurisprudence and legislation, may have the same degree of autonomy as adults to make treatment decisions.

1. Consent to Treatment

A fundamental principle of health law is that, generally, no treatment may be administered without consent.[20] Who provides this consent depends on the patient's "capacity." A capable person is one who understands the nature and purpose of the treatment as well as the reasonably

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18 Generally, courts are reluctant to make parenting orders with respect to older children, as there is a good chance that said children will disregard the order and "vote with their feet." See *CMB v AMB*, 2022 ABQB 528 at paras 125–32.

19 The order may grant a parent all medical decision-making authority or authority over particular treatments. See e.g. *JN v CG*, 2022 ONSC 1198 at 87–88, where the court granted the mother decision-making responsibility over COVID-19 vaccination.

20 There are limited exceptions to this principle. For example, health professionals are permitted to treat without consent in order to save a patient's life or preserve their health in circumstances involving an unforeseen medical emergency where it is impossible to obtain a patient's consent. See *Marshall v Curry*, [1933] 3 DLR 260 (NSSC) at 275, 1933 CanLII 324 (NSSC).

foreseeable consequences of giving or refusing consent.[21] Under the common law, capacity is presumed. If patients are capable, their consent alone is required; if patients are incapable, a substitute decision-maker will provide or refuse consent. Consistent with family law, a parent is usually the substitute decision-maker for an incapable child.[22]

Treatment decisions for capable and incapable people are made according to different standards. Substitute decision-makers must act in accordance with the previously expressed wishes of a prior capable person, or, where the patient's previous wishes are unknown or the patient was never capable, in the patient's "best interests."[23] This is a different standard from the "best interests" standard in parenting cases, although both are used to make decisions for others.[24] Unlike an incapable person, a capable person can make treatment decisions without reference to their "best interests." This means that capable people may refuse treatment that others view as beneficial or necessary, including life-saving treatment.[25]

The right of a capable person to refuse treatment is constitutionally protected. In *Fleming v. Reid*, the Court of Appeal for Ontario held that "[t]he right to determine what shall, or shall not, be done with one's own body and to be free from non-consensual medical treatment, is a right deeply rooted in our common law," and that "[t]he common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order."[26] "This right," according to the court, "forms an essential part of an individual's security of the person and must be included in

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21 Gerald B Robertson & Ellen I Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters, 2017) at 83.

22 *Ibid* at 107–08.

23 Kevin W Coughlin, "Medical Decision-Making in Paediatrics: Infancy to Adolescence" (2018) 23:2 Paediatrics & Child Health 138 at 143.

24 For a discussion on the "best interests" standard in medical decision-making, see Loretta M Kopelman, "The Best Interests Standard for Incompetent or Incapacitated Persons of All Ages" (2007) 35:1 JL Med & Ethics 187.

25 *Starson v Swayze*, 2003 SCC 32 at paras 77–81.

26 1991 CanLII 2728 (ONCA), ss 4, 5 [*Fleming*]. See also *Malette v Shulman*, 1990 CanLII 6868 (ONCA), s 2.

the liberty interests protected by s. 7" of the *Canadian Charter of Rights and Freedoms.*[27]

2. Mature Minors

Certain children may consent to—or refuse—treatment according to either the common law "mature minor" doctrine or under statute.[28] In certain circumstances, child protection law may be used to order treatment of a mature minor.

The common law provides that a child of any age may consent to treatment if they are able to appreciate the nature and purpose of the treatment and the consequences of giving or refusing consent.[29] The House of Lords first recognized the concept of a "mature minor" in *Gillick v. West Norfolk and Wisbech Area Health Authority.*[30] The case considered the potential liability of a doctor who prescribed contraceptives to a teenager without her parents' consent. A majority of the Lords held that children may be capable of consenting to treatment. According to Lord Scarman, "the parental right to determine whether or not their minor child ... will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed."[31]

The Court of Appeal of Alberta's decision in *J.S.C. v. Wren* imported the "mature minor" principle to Canada.[32] The circumstances of the case were like those in *Gillick*: A girl sought reproductive care, a physician was prepared to provide the care, but the parents would not consent. In *Wren*, the proposed treatment was an abortion.[33] Citing *Gillick*, the court found that the sixteen-year-old girl had "sufficient intelligence and

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27 *Fleming*, *supra* note 26, s 5.

28 See Lucinda Ferguson, "The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions" (Paper delivered at the Law Commission of Canada, 29 October 2004) at 11–15 [unpublished], online: <ssrn.com> [perma.cc/G6A7-J7UY].

29 See David C Day, "The Capable Minor's Healthcare: Who Decides?" (2007) 86 Can Bar Rev 379 at 391–92.

30 [1985] UKHL 7 at 168–70.

31 *Ibid* at 188–89.

32 1986 ABCA 249 at paras 10–14.

33 *Ibid* at paras 3, 5, 13.

understanding to make up her own mind," and was therefore entitled to consent to the abortion over her parents' objections.[34]

The common law also protects a mature minor's right to refuse treatment. In *Van Mol v. Ashmore*,[35] the British Columbia Court of Appeal considered whether a surgeon was required to obtain informed consent from a sixteen-year-old patient or from her parent. Justice Lambert explained that once a minor is capable of consent, decisions about 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."[36] The parent of a capable child no longer exercises medical decision-making authority: "All rights in relation to giving *or withholding consent* will then be held entirely by the child."[37]

The Supreme Court considered the scope of a mature minor's right to refuse treatment in *A.C. v. Manitoba* (*A.C.*).[38] Justice Abella, writing for a majority of the Court, described the mature minor doctrine as "a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding."[39] She continued:

> 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.[40]

The majority conceived of the rights of a mature minor at common law as narrower than the rights of a capable adult. Justice Abella stated that no Canadian court had allowed a mature minor to make a treatment

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34 *Ibid* at para 16.

35 *Van Mol v Ashmore*, 1999 BCCA 6 at paras 74–89.

36 *Ibid* at para 75.

37 *Ibid* [emphasis added].

38 *AC v Manitoba (Director of Child & Family Services)*, 2009 SCC 30 at paras 2–3 [*AC*].

39 *Ibid* at para 46.

40 *Ibid*.

decision "likely to jeopardize his or her potential for a healthy future."[41] She further explained that courts have only upheld a mature minor's decision to refuse treatment where the "child's wishes have been consistent with his or her best interests."[42] The implication is that the "best interests" of a mature minor remain relevant to their treatment decisions, while a capable adult may make any treatment decision—even the decision to refuse life-saving treatment—regardless of whether others would perceive the choice as contrary to the adult's "best interests."

Furthermore, the legislative—as opposed to common law—framework governing children's consent to treatment is complex. There is significant variation across provinces and territories, leading to inconsistencies in how children are regarded in different parts of the country. For example, the same child may be capable of consenting to treatment in Ontario and incapable of consent in British Columbia.

Across Canada, children's consent to treatment is legislatively regulated using a combination of presumptions, age restrictions, and "best interests." Some provinces, like Ontario, have codified the common law "mature minor" doctrine.[43] In these jurisdictions, all people are presumed capable, including minors. Other provinces, including New Brunswick, have adopted a rebuttable presumption of capacity for minors of a certain age, typically sixteen years, and a rebuttable presumption of *incapacity* for children under that age.[44] In Quebec, children fourteen years and older may consent to treatment unless the treatment poses a serious risk to the child's health and may cause grave and permanent effects.[45] Quebec also allows courts to order treatment against the wishes of a child fourteen years or older if the treatment is required due to the state of the child's health and is in the their best interests.[46] Other

41 *Ibid* at para 59.

42 *Ibid* at para 62.

43 *Health Care Consent Act*, SO 1996, c 2, Schedule A, s 4.

44 *Medical Consent of Minors Act*, SNB 1976, c M-6.1, s 3.

45 Arts 14, 17 CCQ.

46 *Ibid*, arts 16, 33. Courts have come to different conclusions on whether Quebec law grants jurisdiction to order treatment for "capable" minors over the age of fourteen. See *Centre Universitaire de Santé McGill (CUSM–Hôpital Général de Montréal) c X*, 2017 QCCS 3946 at paras 32–33 [*Centre Universitaire*], and *Hôpital Rivière-des-*

provinces also limit the type of treatment to which a child may consent. For example, in British Columbia, a child may only consent to treatment that is in their best interests.[47] Finally, some provinces, like Saskatchewan, do not have legislation regulating children's consent to treatment and therefore follow the common law.[48]

C. Child Protection Law

Child protection laws may allow courts to override the treatment wishes of mature minors. While parents have a constitutionally protected right to make healthcare decisions on behalf of their child, the state may interfere with this right to protect children from harm.[49] Provincial child protection statutes list failure or refusal to consent to a child's treatment as a ground for protective intervention.[50] Where a child has been apprehended and is in the care of a child protection agency, the agency may ask a court to order treatment in a child's "best interests." Whether a court may order treatment of a mature minor is not clear in every jurisdiction.[51] Until recently, the Supreme Court's decision in *A.C.* arguably provided support for respecting the treatment wishes of a mature minor in state care. However, the recent decision of the Court of Appeal of Alberta in *J.I. v. Alberta* (*J.I.*)[52] suggests that a court acting under a child protection statute *can* override the treatment wishes of a mature minor in some circumstances.

Prairies du Centre Intégré Universitaire de Santé et de Services Sociaux du Nord-de-l'Île-de-Montréal (CIUSSS NIM) c X, 2018 QCCS 4673 at para 25.

47 *Infants Act*, RSBC 1996, c 223, s 17(3). Where a capable child refuses to consent to treatment that is in their best interests, a court acting under British Columbia's child protection statute can order treatment where it is "necessary to preserve the child's life or to prevent serious or permanent impairment of the child's health" (see *Child, Family and Community Service Act*, RSBC 1996, c 46, s 29). By contrast, a capable child in Ontario need not act in their best interests in refusing or consenting to treatment (see *Health Care Consent Act*, SO 1996, c 2, Schedule A, s 4).

48 Coughlin, *supra* note 23 at 140.

49 *BR, supra* note 13.

50 See *Child, Youth and Family Services Act*, SO 2017, c 14, Schedule 1, s 74(2)(e).

51 In some jurisdictions, like Ontario, a child protection agency has no greater authority to make a treatment decision for a capable child than would a parent. See *ibid*, s 110(2).

52 *JI v Alberta (Child, Youth and Family Enhancement Act, Director)*, 2023 ABCA 169 at para 51 [*JI*].

1. *A.C. v. Manitoba*

A.C. considered the constitutionality of a child protection statute that allowed a court to override the treatment wishes of younger adolescents irrespective of capacity. AC was a nearly fifteen-year-old Jehovah's Witness who refused to consent to a life-saving blood transfusion.[53] Manitoba's *Child and Family Services Act* provided no authority to order treatment for a child who was sixteen or older and capable of consenting to treatment, but allowed a court to order treatment for a child under sixteen where such treatment was in the child's "best interests."[54] AC was apprehended and the court, applying the statute, ordered the blood transfusion. AC challenged the constitutionality of the relevant provisions, arguing that the provisions failed to account for the capacity of young people under the age of sixteen, and that as a "mature minor" she should be entitled to refuse treatment.[55] A majority of the Supreme Court held that if the "best interests" of a child under sixteen were "interpreted in a way that sufficiently respects [a child's] maturity," the statute would be constitutional.[56]

The majority decision attempted to balance children's welfare and autonomy. Writing for the majority, Justice Abella explained that "[m]ature adolescents ... have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is [also] justified."[57] The majority offered a "sliding scale" to determine the weight to be attached to a child's views in deciding whether to order treatment in the child's "best interests" under the statute:[58]

> [T]he adolescent's views becom[e] increasingly determinative depending on his or her ability to exercise mature, independent judgment. The more serious the nature of the decision, and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny that will be required.

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53 AC's parents supported her decision, so there was no conflict between the child's views and the parents' views. See *AC*, *supra* note 38 at para 6.

54 *Ibid* at para 15.

55 *Ibid* at para 25.

56 *Ibid* at para 3.

57 *Ibid* at para 82.

58 *Ibid* at para 22.

In other words, the more mature the child, the more likely a court will respect their treatment wishes. But the more serious the potential consequences of the treatment decision, the less likely a court will respect a child's views.

While assessing maturity is a complex and individualized task, the "best interests" standard under the statute was not "a licence for the indiscriminate application of judicial discretion."[59] To "divorce the application of the best interests standard from an assessment of the mature child's interest in advancing his or her own autonomous claims," Justice Abella warned, "would be to endorse a narrow, static and profoundly unrealistic image of the child and of adolescence."[60]

A.C.'s application to children's treatment decisions is limited. In most cases, the child's life "will not be gravely endangered by the outcome of any particular treatment decision."[61] In those cases, a treatment provider is generally free to rely on the consent of a young person who seems to demonstrate sufficient maturity.[62] It is only in the "very limited class of cases" where a child protection agency has concluded that medical treatment is "necessary to protect [the child's] life or health," and either the child or the parents have refused to consent, that the state retains "an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests."[63]

2. *J.I. v. Alberta*

A.C. considered the constitutionality of a child protection statute that set the presumed age of consent at sixteen. In the recent case of *J.I.*, the Court of Appeal of Alberta considered the constitutionality of a child protection statute that is silent on capacity to consent to treatment.

JI was a fourteen-year-old girl who also refused a blood transfusion based on her Jehovah's Witness faith. Child protective services

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59 *Ibid* at para 91.

60 *Ibid*.

61 *Ibid* at para 85.

62 *Ibid*.

63 *Ibid* at para 86.

apprehended JI and obtained a court order authorizing a blood transfusion. JI's condition subsequently improved and she did not receive the transfusion.[64] JI appealed the apprehension and treatment orders, arguing that the relevant provisions of Alberta's *Child, Youth and Family Enhancement Act* were unconstitutional. Section 22.1(2) of the Act states that where a child has been apprehended and the child's guardian refuses to consent to "essential medical, surgical, dental or other remedial treatment ... that is recommended by a physician," a child protection agency must apply to a court for an order authorizing the treatment.[65] Section 22.1(5) authorizes the court to order treatment in the "best interests" of the child.[66] JI argued that the statute would only be constitutional if it prevented courts from making treatment orders against mature minors. In other words, the treatment wishes of a mature minor had to be followed.

The Court of Appeal relied on *A.C.* to find that a court acting under Alberta's child protection statute could order treatment for a mature minor in certain circumstances. Consistent with the Supreme Court's reading of the Manitoba provisions in *A.C.*, it interpreted the Alberta statute to "require that the wishes of the mature minor be taken into consideration."[67] The Court of Appeal also accepted that, under the Alberta statute, "there will come a point where the adolescent's views become increasingly determinative such that the principles of welfare and autonomy collapse altogether and the adolescent's wishes become the controlling factor."[68] However, according to the court, *A.C.* also recognized, "a residual jurisdiction in the Court to override [a mature minor's treatment] decision where life or health are endangered."[69] This "confirms that the constitutional validity of child welfare statutes does not require that a mature minor be given a veto over his or her medical care."[70]

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64 *Ibid* at paras 8–11, 13.

65 *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12, s 22(1)(2).

66 *Ibid* ss 22(1), (5).

67 *JI*, *supra* note 52 at para 35.

68 *Ibid*.

69 *Ibid* at para 18. At least one Quebec court has come to a similar conclusion. See *Centre Universitaire*, *supra* note 46 at para 38.

70 *JI*, *supra* note 52 at para 34.

II. FAMILY LAW CASES DECIDING CHILDREN'S TREATMENT DISPUTES

Parenting disputes over children's healthcare raise a similar issue: Can a court acting under a family law statute order treatment over the wishes of a mature minor? There have been more than a few recent cases in which separated parents have asked family courts to resolve disputes over adolescents' treatment. Courts approach these cases in one of three ways. The first approach is to apply health law instead of family law. The second approach is to draw on health law principles in applying family law. The third approach is to apply family law instead of health law. Because different provinces have different health laws, there is some variation across jurisdictions. However, courts in the same province have also taken conflicting approaches.

A. Health Law, Not Family Law

A handful of decisions approach parenting disputes over a child's treatment through the lens of health law, rather than family law. The best example comes from the Ontario case of *Warren v. Charlton*. The parties had three children ages fourteen, twelve, and five. The parties had already agreed that the mother would have decision-making responsibility over the twelve-year-old, S. However, decisions related to healthcare were specifically left outstanding in this delegation of responsibility, and the parents could not agree on whether S should be vaccinated.[71] Referencing Ontario's *Health Care Consent Act, 1996* (*HCCA*), which presumes that everyone—including those under 18—is capable, Justice Ramsay noted that "[d]epending on the child, the question [of vaccination] may be determined without reference to parental authority."[72] Justice Ramsay found that "it was obvious and all but conceded that [S] is capable of consenting to vaccination."[73] As a result, even if the court were to grant the father decision-making responsibility in a healthcare context, "[S would] still have the right to withhold his consent."[74] Importantly, the

71 2022 ONSC 1088 at paras 1–2, 5–6 [*Warren*]. See also *AC v LL*, 2021 ONSC 6530 at paras 33–42.

72 *Warren*, *supra* note 71 at para 11.

73 *Ibid* at para 12.

74 *Ibid* at para 13.

court did not engage in a "best interests" analysis. Having found that S was capable of providing consent, Justice Ramsay also dismissed the father's concern that the mother—whom he felt held "bizarre" views bordering on anti-vaccination rhetoric—might discourage S from being vaccinated, saying: "Whether his mother's influence [would be] behind it or not is ultimately irrelevant."[75]

In *Gegus v. Bilodeau*, another Ontario case, an appeals decision held that the *HCCA* was ultimately determinative in children's medical decision-making. The parents shared custody of a child who was diagnosed with attention deficit hyperactivity disorder (ADHD).[76] When the child was around thirteen or fourteen years old, the mother obtained an order granting her "the exclusive right to consent to the prescribing of ADHD medication to [the child]."[77] The father appealed. One of the grounds of appeal was that the motions judge failed to consider the *HCCA*. The father argued that the child did not consent to being medicated. Justice Bryne clarified that the order dispensed with the father's consent in the event that the child was *incapable* of consenting to treatment. It did not oust the need for the child, if capable, to consent to treatment: "[N]othing in the decision of the motions judge takes away the child's primary right to accept or refuse treatment, if the health practitioner is satisfied that the child has the capacity to do so."[78]

In *A.B. v. C.D.* (*A.B.*)—a family law dispute—the British Columbia Court of Appeal applied the province's *Infants Act*, which governs children's consent to treatment. The parents shared decision-making responsibility for a fourteen-year-old transgender boy, AB. AB was diagnosed with "gender dysphoria," and hormone therapy was medically recommended. AB and his mother consented to the treatment, but the father refused.[79] Under the *Infants Act*, a child may consent to treatment where a medical provider determines that the child understands the

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75 *Ibid*.

76 *Gegus*, *supra* note 4 at para 1.

77 *Ibid*.

78 *Ibid* at para 52. In his reasons, Justice Whitling clarified that the order being made was for the father to be able to take the child to a vaccination appointment; it was not an order directing that the child be vaccinated. However, the judge did not reference the possible application of health law (see *Sembaliuk*, *supra* note 1 at para 23).

79 *AB*, *supra* note 3 at paras 13, 15.

nature, consequences, and reasonably foreseeable benefits of the treatment, and where the treatment is in the child's best interests.[80] Two medical providers determined that AB had capacity to consent to hormone therapy and that the therapy was in his best interests.[81] The father applied for an injunction to prevent AB from receiving hormone therapy, arguing that the treatment was not in AB's best interests. AB applied for a declaration that he was entitled to make his own medical decisions. A lower court dismissed the father's application and allowed the treatment to proceed. This part of the decision was affirmed on appeal.[82]

The British Columbia Court of Appeal in *A.B.* explained the interplay between the *Infants Act* and the *Family Law Act*, the latter of which authorizes parenting orders. A court may review a capacity determination under the *Infants Act*. However, a court has limited authority to review a medical practitioner's assessment that a particular treatment is in the "best interests" of the child.[83] According to the Court of Appeal, the *Infants Act* "has made it clear that health care professionals, not judges, are best placed to conduct inquiries into the state of medical science and the capacity of their patients when it comes to questions of minors' medical decision-making."[84] This statutory deference to health care providers, the Court explained, "appropriately protects minors' medical autonomy by providing a limited scope of review."[85] This means that a parent cannot use the *Family Law Act* to challenge a capacity finding under the *Infants Act*.

B. Health Law-Infused Family Law

Other family law cases consider health law principles like autonomy and bodily integrity when applying family law to resolve parental disputes over children's treatment. In *J.N. v. C.G.*, an Ontario case that was later

80 *Ibid* at para 117.

81 *Ibid* at paras 14–15.

82 *Ibid* at paras 25–69.

83 *Ibid* at para 114.

84 *Ibid* at para 137.

85 *Ibid*.

appealed,[86] the mother had sole decision-making responsibility for two children, ages twelve and ten. The father brought a motion requesting that the children be vaccinated against COVID-19, which the mother opposed. The children did not want to be vaccinated, and the social worker who prepared a Voice of the Child Report said she had "no concerns or suspicions about either child being manipulated or pressured by either parent."[87] Justice Pazaratz described the case as follows: "In this case, the children's views have been *independently* ascertained — *they both don't want to receive the COVID vaccines* — but the father is asking me to ignore how they feel and force them to be vaccinated against their will."[88] Justice Pazaratz rejected the father's request, and ordered that the mother have "sole decision-making authority with respect to the issue of administering COVID vaccines" for the two children.[89] Applying the "best interests" test, Justice Pazaratz held that "significant weight should be given to each child's stated views and requests."[90] Notably, the judge expressed "concern[] that any attempt to ignore either child's views on such a *deeply personal and invasive issue* would risk causing emotional harm and upset."[91]

Other courts have incorporated the "mature minor" principle into the "best interests" analysis. In the Ontario case of *M.M. v. W.A.K.*, the parents shared custody of a twelve-year-old child. The father brought a motion requiring the mother to ensure that the child was vaccinated against COVID-19 and other diseases.[92] The child was "strongly opposed" to receiving the COVID-19 vaccine.[93] The father introduced a note from the family doctor saying it was "highly suggested that [the child] be vaccinated with the Covid-19 vaccination. She has no known contraindications for the vaccine."[94] Justice Corkery applied the "best

86 2022 ONSC 1198 [*JN* SC]; *JN* CA, *supra* note 1 at paras 1–2. The appeal decision is discussed in the following section.

87 *JN* SC, *supra* note 86 at para 29(h).

88 *Ibid* at para 29 [emphasis in original].

89 *Ibid* at paras 87–88.

90 *Ibid* at para 78.

91 *Ibid* [emphasis added].

92 *MM v WAK*, 2022 ONSC 4580 at paras 1–2, 5–6.

93 *Ibid* at para 55.

94 *Ibid* at para 24.

interests" test under the *Divorce Act*, with particular attention to "the child's views and preferences," and found that "requiring [the child] to be vaccinated against her will would not respect her 'physical, emotional and psychological safety, security and well-being' but would, in fact, place her at risk of serious emotional and psychological harm."[95] Justice Corkery also suggested that ordering vaccination against the child's will would "foster[] resentment toward the court and its process."[96] Finally, Justice Corkery found that the child was a "mature minor" according to *A.C.* and capable under the *HCCA*.[97] Based on these factors, the court concluded it was not in the child's "best interests" to order vaccination.

The case of *Rouse v. Howard*, also from Ontario, offered similar reasoning. The father brought an emergency motion for sole decision-making responsibility for a nine-year-old child on the specific issue of vaccination against COVID-19. The mother opposed all vaccinations, and the child had never received a vaccine.[98] The child held "the same beliefs as her mother regarding the necessity and benefits of vaccines."[99] While Justice Hilliard did not address the child's capacity to consent, she did note that the *HCCA* does not provide a minimum age for consent and excerpted a description of the "mature minor" doctrine from *AC*. Justice Hilliard also expressed concern that "[a]n order granting [the father] decision-making authority would result in [him] having the ability to override [the child's] *right* to withhold her consent to vaccination which may have negative emotional and/or psychological consequences."[100] Ultimately, Justice Hilliard held that it would not be in the child's "best interests at present" to order the father to have sole decision-making responsibility with respect to vaccination against COVID-19.[101] The issue of vaccines would have to be reconsidered before or at trial.

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95 *Ibid* at para 56.

96 *Ibid* at para 57.

97 *Ibid* at para 59.

98 *Rouse v Howard*, 2022 ONCJ 23 at paras 1, 4.

99 *Ibid* at para 19.

100 *Ibid* at para 18 [emphasis added].

101 *Ibid* at para 24 [emphasis in original].

C. *Family Law, Not Health Law*

Finally, most courts deciding parental disputes over children's treatment rely exclusively on family law. In most of these cases, health law is not mentioned. For example, in the Prince Edward Island case of *P.R. v. S.R.* (*P.R.*),[102] the father filed an emergency motion seeking sole responsibility to make all vaccination and health related decisions for the parties' three children, ages eleven, nine, and six. The mother was opposed to vaccinating the children against COVID-19. While Prince Edward Island, like Ontario, does not have a minimum age of consent to treatment, the children's views on vaccination were not before the court. In fact, the children's lawyer had not spoken to the children about vaccination and submitted that "it [was] better not to ask the children lest they have been influenced by their parents' beliefs, negative feelings, and behavior towards one another."[103] It was the children's lawyer's view that it was in the children's "best interests" to be vaccinated, and the court agreed. The father was permitted to take the children to be vaccinated and was ordered to provide proof of vaccination to the mother and the court.[104]

A similar approach was taken by the Court of Appeal for Ontario in *J.N. v. C.G.* (*J.N.*), discussed above.[105] The father appealed the order of Justice Pazaratz on multiple grounds, including his finding that the children's views were independent. The Court of Appeal held that the motions judge erred in failing to acknowledge evidence that the mother had influenced the children's views, including the ten-year-old's statement to the social worker who prepared the Voice of the Child Report that "in every case [where] the vaccine had been tested on animals the animals had died."[106] Although the social worker ultimately determined that the children had not been influenced, the Court of Appeal found that the motions judge erred in giving the children's views "any weight."[107] Whereas the motions judge had alluded to the "deeply personal and

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102 *PR*, *supra* note 1 at para 9.

103 *Ibid* at paras 66–67.

104 *Ibid* at paras 72–81.

105 *JN* CA, *supra* note 1 at para 35.

106 *Ibid* at para 33.

107 *Ibid* at para 36.

invasive" issue of vaccination,[108] the Court of Appeal did not consider how ignoring the children's treatment wishes would threaten their autonomy or bodily integrity. Rather than send the case back for reconsideration, the Court of Appeal granted the father sole decision-making authority over the children's vaccination. The Court relied on the assurance of the father's counsel that "[the father's] objective [was] not to force vaccination upon the children."[109] While the motions judge described the father's "shameless efforts to vilify the mother by ridiculing her personal beliefs [as] border[ing] on hysterical" and characterized the father's view as encouraging the court to "completely ignore how [the children] feel about what they experience and what their bodies are subjected to,"[110] the Court of Appeal found there was "no reason to doubt the [father's] motivation and stated desire to approach this very sensitive issue in a measured way and with a view to the children's best interests."[111]

Like *P.R.* and *J.N.*, the Court of Appeal for Ontario's decision in *A.M. v. C.H.* exclusively relied on family law to resolve a dispute over a child's treatment. The case is significant for what it says about the interplay between Ontario's *HCCA* and family law statutes.[112] The main issue at trial was the parenting arrangements of the parties' fourteen-year-old son. The son was resisting contact with the father. The children's lawyer took the position that the child's views were independent and supported his wishes to terminate or reduce time with his father.[113] The father alleged that the mother was alienating the child, and the trial judge agreed. Having found that the child was "poisoned against his father and [that] his views are not his own," the trial judge refused to give the child's wishes "any weight."[114] The trial judge ordered a transfer of custody from the

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108 *JN* SC, *supra* note 86 at para 78.

109 *JN* CA, *supra* note 1 at paras 48–49.

110 *JN* SC, *supra* note 86 at paras 43, 30.

111 *JN* CA, *supra* note 1 at para 48.

112 For a more recent case applying *AM*, see *CB v EG*, 2023 ONSC 1571. Justice Bale relied on *AM* to find that the *HCCA* was "not a controlling factor" in deciding whether to order a sixteen-year-old to attend reunification therapy. Nevertheless, the court held that it was not in the child's best interests to order therapy. Importantly, the court considered the possibility that a therapist might refuse to provide services given the child's "mature objection under the *HCCA*" (at paras 29, 38).

113 *AM*, *supra* note 2 at paras 3, 14.

114 *Malhotra v Henhoeffer*, 2018 ONSC 6472 at para 152 [*Malhotra*].

mother to the father, suspended access between the mother and the child, and ordered the child to attend "reconciliation therapy."[115]

The mother appealed, arguing that the trial judge erred in ordering the child to participate in "reconciliation therapy" without his consent, contrary to the *HCCA*.[116] The Court of Appeal for Ontario affirmed the trial judge's order. It found that the *HCCA* did not apply in this case. The *HCCA*, according to the court, concerns the relationship between individuals and health care practitioners. It "aims to protect a person's autonomy to make decisions about their own well-being, even if those decisions are not in their best interests."[117] Custody decisions, on the other hand, prioritize the "best interests" of the child.[118] Moreover, the Court of Appeal stated that while the *Child, Youth and Family Services Act*, Ontario's child protection statute, recognizes the authority of the *HCCA*, the family law statutes (the *Divorce Act* and Ontario's *Children's Law Reform Act*) do not, suggesting that the family law statutes govern.[119] According to the Court of Appeal, where parents cannot agree, a family court "may make orders about almost any aspect of the child's life, including education, religious training, diet, vaccinations, recreation travel, and so on. This includes making an order for counselling or therapy," even if the child is capable.[120]

This is not to say that children's autonomy is irrelevant in family law disputes. A child's "views and preferences" are a factor in considering the child's "best interests," but they are not determinative. Relying on *A.C.*'s analysis of Manitoba's child protection statute, the Court of Appeal said that the weight to be attached to a child's treatment wishes in a parenting dispute would depend on the child's "maturity." Here, the trial judge found that the child had been alienated by the mother and that his views

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115 The order compelling the child to attend reunification therapy was made after the original order. See *AM*, *supra* note 2 at para 44.

116 *Ibid* at para 4.

117 *Ibid* at para 58.

118 *Ibid* at para 60.

119 *Ibid* at paras 64–65.

120 *Ibid* at para 51. There is some disagreement over whether reconciliation therapy constitutes "treatment" under Ontario's *Health Care Consent Act*, *supra* note 43, s 4 (see *Leelaratna*, *supra* note 2 at paras 66–67; *Barrett v Huver*, 2018 ONSC 2322 at para 39). The Court of Appeal for Ontario did not directly address this issue in *AM*.

were not his own.[121] In other words, "the child lacked the requisite maturity to refuse counselling with his father."[122] In these circumstances, the trial judge was entitled to put "no weight on the child's wishes" and order him to attend therapy.[123]

Whether the child would receive therapy was a different issue. Therapists must follow the *HCCA*, even if family courts do not. The Court of Appeal acknowledged that "[a] health care practitioner may consider that the child is capable and that he or she cannot override the child's refusal."[124] In that case, not much could be done: "Courts cannot fix every problem."[125]

Finally, the Court of Appeal for Saskatchewan's decision in *O.M.S. v. E.J.S.* demonstrates how a court may discount a child's treatment refusal but nonetheless refuse to order treatment in the child's "best interests."[126] The parties in *O.M.S. v. E.J.S.* had two children. The mother exercised decision-making authority over education and medical matters for the children. The father applied for an order authorizing him to have the parties' almost thirteen-year-old daughter vaccinated. The child, who was diabetic, did not want to be vaccinated. The mother also opposed vaccination.[127] A psychotherapist interviewed the child and concluded that she was "mature, [and] had endured chronic illness, repeated medical procedures, and ... fearful incidents."[128] At some point, the father

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121 *Ibid* at paras 67–68.

122 *AM*, *supra* note 2 at para 75.

123 *Ibid* at paras 27, 75.

124 *Ibid* at para 72.

125 *Ibid*. Not long after the appellate decision, family lawyer Philip Epstein reported that the child "had apologized to his father and is now living with him." This was evidence that the custody transfer had been "successful" (see Philip Epstein, "Epstein's This Week in Family Law" (2019) 49 Family L Newsletters). As I have pointed out in commentary on the case, this "success" followed the child being arrested, placed in a group home, and seriously assaulted, causing injuries requiring plates to be implanted in his face (see Houston, "Case Comment", *supra* note 2 at 102). Mr. Epstein's commentary suggests that children who refuse treatment may later change their minds—something that is also true for adults. It is not clear what has happened to the child since Mr. Epstein's report.

126 *OMS* CA, *supra* note 1 at paras 94–95.

127 *Ibid* at paras 2, 4, 8–9.

128 2021 SKQB 243 at para 22 [*OMS* QB].

engaged in behaviour that caused the child to express a desire to self-harm, leading to medical intervention.[129] The psychotherapist supported the child's treatment refusal, and noted that "the risks of the current court case outweigh any benefit to the child to be vaccinated."[130]

A judge in chambers ordered the child to be vaccinated. The chambers judge applied a "best interests" analysis, saying that in considering the child's views and preferences, he was required to consider the "mature minor" doctrine.[131] While the chambers judge found that the child was "a mature, bright, and capable young woman,"[132] he believed that the mother and paternal grandparents had influenced her treatment views, which thus rendered them not independent. He also noted that, "[s]he is, after all, a child. She is 12."[133] After accepting that the vaccine would reduce the child's risk of contracting COVID-19, the chambers judge determined that it was in the best interests of the child to be vaccinated.[134]

The Court of Appeal for Saskatchewan reversed the chambers judge's order. The court found that the chambers judge erred in focusing exclusively on the child's physical well-being were she to receive the COVID-19 vaccine. In determining "best interests," courts must consider the child's physical as well as emotional and psychological safety, security and well-being.[135] In this case, there was evidence that ordering the child to be vaccinated against her wishes might cause emotional and psychological harm. First, there was a small possibility that forced vaccination could lead the child to self-harm, something she had considered in the past. Second, the child's history of medical and other trauma placed her at risk of longer-term mental health problems were she to be forcibly vaccinated.[136] Third, forcing the child to be vaccinated at the father's insistence was likely to damage the already fraught relationship between the two: "An order which might damage an already tenuous relationship with

129 *Ibid* at paras 54–55.

130 *Ibid* at para 22.

131 *Ibid* at para 80.

132 *Ibid* at para 83.

133 *Ibid* at para 89.

134 *Ibid* at paras 119–20.

135 *Divorce Act*, *supra* note 6, s 16(2).

136 *OMS* CA, *supra* note 1 at paras 86, 89.

a parent presents a real risk of causing the very harm that orders made pursuant to the *Divorce Act* are meant to avoid."[137]

The Court of Appeal "set off to the side" the mature minor doctrine.[138] While it is not entirely clear from the chambers judge's decision, he seems to have dealt with the child's capacity to consent by finding that she was "not ... speaking independently."[139] Saskatchewan does not have health care consent legislation and therefore relies on the common law. The common law recognizes that a child may consent to treatment where they are able to appreciate the nature and purpose of the treatment and the consequences of giving or refusing consent.[140] Rather than determining whether the chambers judge applied the doctrine correctly, the Court of Appeal stated: "Assuming, without deciding, that the mature minor doctrine is limited to circumstances when a child can be said to be speaking independently, there is ample evidence supporting this finding."[141]

III. DISCUSSION: AUTONOMY *AND* BEST INTERESTS

The tension between family law and health law in parenting disputes over children's treatment maps onto a larger debate about protecting children's welfare versus promoting children's autonomy. Other scholars have intervened in this debate, and in what follows, I draw on this work to suggest a framework for resolving the tension between family law and health law in parenting disputes over children's treatment.

A. Promoting Children's Current and Future Autonomy

Parenting disputes over children's treatment raise familiar questions about how to govern children's lives. Children are different from adults; they are temporarily dependent on adults and lack competency to make their own decisions. This dependency leaves them vulnerable, hence why we have laws dedicated to their protection. At the same time, children's capacities are developing, and they may reach a point where their

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137 *OMS* CA, *supra* note 1 at paras 86–93.

138 *Ibid* at para 94.

139 *OMS* QB, *supra* note 128 at para 88.

140 Coughlin, *supra* note 23 at 140.

141 *OMS* CA, *supra* note 1 at para 94.

decision-making capacity compares to that of (many) adults.[142] This fact is reflected in "mature minor" doctrine and statutes.

The tension between family law and health law in parenting disputes over children's treatment reflects a larger tension between protecting children's welfare and promoting children's autonomy. With the suggestion that children have rights, and the introduction of the *United Nations Convention on the Rights of the Child* (*UNCRC*), we have moved away from a purely protectionist model for regulating children's lives.[143] While there is debate over whether children possess moral rights,[144] conferring legal rights on children is, at a minimum, an attempt to recognize that children have interests that overlap and diverge from those of adults.[145] Nevertheless, there remains more support for recognizing children's

142 Research on adolescent decision-making suggests that children as young as ten may have capacity to make certain medical decisions (see Irma M Hein et al, "Accuracy of the MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR) for Measuring Children's Competence to Consent to Clinical Research" (2014) 168:12 JAMA Pediatrics 1147 at 1151–52. For a finding that suggests adolescents fifteen and older can demonstrate adult-like levels of maturity for decision-making capacity in non-emotional contexts, see also Laurence Steinberg, "Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?" (2013) 38:3 J Medicine & Philosophy 256 at 263. For a finding that fourteen year olds may have comparable decision-making capacity to adults, see Lois A Weithorn & Susan B Campbell, "The Competency of Children and Adolescents to Make Informed Treatment Decisions" (1982) 53:6 Child Development 1589 at 1595. For a review of the literature that suggests that children eleven and older generally exhibit decision-making capacity, see Petronella Grootens-Wiegers et al, "Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects" (2017) 17:120 BMC Pediatrics 1 at 7–8.

143 For a description of the shift from protectionism to children's rights, see Fiona Kelly, "Conceptualising the Child Through an 'Ethic of Care': Lessons for Family Law" (2005) 1:4 Intl JL in Context 375 at 376–82.

144 For instance, Onora O'Neill, argues that it is more appropriate to think in terms of adult obligations toward children than children's rights (see e.g. Onora O'Neill, "Children's Rights and Children's Lives" (1988) 98:3 Ethics 445 at 445–46).

145 Joel Feinberg calls rights that are common to adults and children "A-C rights," and rights normally specific to children "C-rights." C-rights include rights that derive from dependence (i.e., the right to food and shelter) and rights that are held "in trust" (i.e., autonomy). Joel Feinberg, "The Child's Right to an Open Future" in Joel Feinberg, ed, *Freedom and Fulfillment: Philosophical Essays* (Princeton, NJ: Princeton University Press, 2021) 76 at 76–78.

"welfare rights" (i.e., the right to be free from abuse) than "liberty rights" (i.e., the right to self-determination).[146]

This tension between protection and autonomy is manifest in the *UNCRC*.[147] Article 3 directs that "the best interests of the child shall be a primary consideration" in all actions concerning children and requires states parties to ensure that the child receives "such protection and care as is necessary for his or her well-being."[148] At the same time, article 12 grants any child capable of forming their own views the right to express those views and to have those views "given due weight in accordance with the age and maturity of the child."[149] Article 12 seems to contemplate decision-making authority on the part of some children.

Scholars have attempted to reconcile the tension between articles 12 and 3, as well as between children's best interests and autonomy, more generally.[150] These accounts incorporate children's autonomy into "best interests" decision-making, even where a child's wishes do not determine the outcome.[151] Some of these accounts focus on cultivating a child's future autonomy, while others prioritize children's present autonomy to determine their own best interests. These attempts to reconcile children's welfare and autonomy offer guidance on how to resolve the tension

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146 Michael Freeman, "Whither Children: Protection, Participation, Autonomy?" (1994) 22:3 Man LJ 307 at 322 [Freeman, "Whither Children"].

147 The CRC does not specifically address children's healthcare decision-making. However, the Committee on the Rights of the Child has recommended that state parties legislate a fixed age at which children may consent to their own treatment (see *General Comment No 12: The Right of the Child to be Heard*, UNCRC, 55th Sess, UN Doc CRC/C/GC/12 (2009) at para 102).

148 *Convention on the Rights of the Child*, UNGA, 44th Sess, UN Doc A/RES/44/25 (1989) GA Res 44/25, art 3.

149 *Ibid*, art 12.

150 See e.g. Michael Freeman, *The Rights and Wrongs of Children* (London, UK: Frances Pinter, 1983) at 267–71 [Freeman, *Rights and Wrongs*]; John Eekelaar, "The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism" (1994) 8:1 Intl JL Pol'y & Fam 42 at 42–43; David Archard, *Children: Rights & Childhood*, 3rd ed (London, UK: Routledge, 2015) at 119–23; Joel Anderson & Rutger Claassen, "Sailing Alone: Teenage Autonomy and Regimes of Childhood" (2012) 31:5 Law & Phil 495; Aoife Daly, *Children, Autonomy and the Courts: Beyond the Right to be Heard* (Leiden, Netherlands: Brill, 2018) at 71.

151 See David Archard & Marit Skivenes, "Hearing the Child" (2009) 14:4 Children & Family Soc Work 391 at 397–98.

between family law and health law in parenting disputes over children's treatment.

B. A Roadmap for Courts

I suggest that the apparent tension between family law and health law in these cases can be resolved by applying health law in cases involving *capable* minors and drawing on health law principles, including autonomy, when assessing "best interests" in cases of *incapable* children. This approach incorporates children's present and future autonomy interests into best interests decision-making and is consistent with the Supreme Court of Canada's majority decision in *A.C.*

The first question a family court should ask when faced with a parenting dispute over a child's treatment is whether the child is capable of consenting to the treatment.[152] A child's capacity will depend on the province or territory in which the child resides. Generally, the test for capacity is whether a person understands the nature and purposes of a proposed treatment as well as the reasonably foreseeable consequences of giving or refusing consent.[153] This includes appreciating the risks and benefits of the proposed treatment, as well as any alternatives. Capacity to consent is treatment-specific; someone may have capacity to consent to one treatment but not another.[154]

There are principled and practical reasons why family courts should defer to the treatment wishes of a capable child in a parenting dispute. Parenting orders are made according to what a court determines is in the "best interests" of the child. However, where common law or statute directs that a child has capacity to make a treatment decision, a best

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152 Treatment providers are responsible for assessing a child's capacity to consent. However, in many parenting disputes over children's treatment, a court will not have the benefit of a capacity assessment from the proposed treatment provider. If a child's capacity to consent to the proposed treatment is in doubt, the order granting one parent decision-making responsibility over the treatment decision should specify that the order is subject to the child's capacity to consent to the treatment (see e.g. *Gegus*, *supra* note 4 at para 52).

153 Robertson & Picard, *supra* note 21 at 83.

154 Joan M Gilmour, "Legal Capacity and Decision-Making" in Joanna N Erdman, Vanessa Gruben & Erin Nelson, eds, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis Canada, 2017) 351 at 355–56.

interests analysis is no longer appropriate and the child's decision should govern. This applies to parents making health care decisions for children and should apply to courts exercising the same duty.

Moreover, it would be incongruous for family courts acting under parenting statutes to have powers not available to family courts acting under child protection statutes.[155] In some jurisdictions, like Ontario, a child protection judge cannot order a capable child to receive treatment.[156] This reflects the role of the state *as parent* in child protection matters.[157] Just as a parent in Ontario cannot override the treatment wishes of a mature minor, neither may a court exercising its parens patriae jurisdiction under a child protection statute.

Parenting disputes over children's treatment are different from child protection cases in which a child is refusing treatment. Child protection decisions are based on a finding that the child has been harmed or is at risk of harm. The Court of Appeal of Alberta decision in *J.I.* suggests that a court acting under a child protection statute may override a capable child's treatment wishes only in limited circumstances. It is not clear, at least from the Supreme Court of Canada's decision in *A.C.*, whether such an override is constitutional. Regardless, any ability of a court acting under a child protection statute to override a capable child's treatment wishes cannot be transferred to a court acting under a parenting statute *where a child has not been found in need of protection*. Indeed, *J.I.* suggests that a court acting under a child protection statute can only compel treatment of a capable child where the life or health of the child is in danger.[158]

In most parenting disputes, the proposed treatment or refusal of treatment will not create a risk of harm sufficient to override a capable child's treatment wishes. For example, most of the cases surveyed involve children refusing COVID-19 vaccines. While vaccine refusal poses a risk

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155 See Day, *supra* note 29 at 385. See also Houston, "Case Comment", *supra* note 2 at 107.

156 Day, *supra* note 29 at 385.

157 See *R v Gyngall*, [1893] 2 QB 232 at 239, where Lord Esher described parens patriae as "a paternal jurisdiction … in virtue of which the Chancery Court was put to act on behalf of the Crown, as being the guardian of all infants, in the place of a parent, and as if it were the parent of the child."

158 See also *Centre Universitaire*, *supra* note 46 at paras 36–37.

of harm to children,[159] it is not generally sufficient to warrant child protection intervention.[160] A parent has discretion to refuse to vaccinate their child, and it would be incoherent for that discretion to evaporate once decision-making authority is transferred from the parent to the mature child.

Family courts should be careful not to apply a best interests standard when assessing capacity. Some courts assume that children as a class are incapable of consenting to treatment.[161] As Michael Freeman has pointed out, "[i]t is much easier to assume abilities and capacities are absent than to take cognizance of children's choices."[162] Other courts determine capacity based on the nature of the child's wishes. This allows courts to dispute capacity where the child's choice is unpopular. Mona Paré, for example, has observed that, "[c]onclusions about capacity and the right to make certain decisions are too often really backdoor assessments about the reasonableness of the decision rather than the capacity of the person to make it in the first place."[163] The impulse to protect children from themselves means family courts may also hold children to a higher competency standard than adults.[164] For example, family courts often cite parental "influence" to question children's capacity without acknowledging that even adults do not make medical decisions in a

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159 There is a very strong case to be made that parents who refuse childhood vaccinations do not act in their children's best interests (see Braley-Rattai, *supra* note 9). Hunt Federle also advances a child rights-based argument for mandated immunization (see Hunt Federle, "The Child's Right to Be Vaccinated" (2021) 29:4 Intl J Child Rts 897 at 899).

160 A 2021 review of Canadian decisions found one case in which a parent's failure to vaccinate their child justified child protection intervention (see Kate Allen & Eliza Livingston, *Vaccination and Child Welfare: Does Vaccine Hesitancy Constitute Medical Neglect?* (Montreal: Canadian Child Welfare Research Portal, 2021) at 4). In this decision, the court ordered that a newborn baby whose mother was a Hepatitis B carrier be vaccinated against Hepatitis B (see *Children's Aid Society of Peel (Region) v H(TMC)*, 2008 ONCJ 20 at para 35).

161 See e.g. *OMS* QB, *supra* note 128 (where the court dismissed the child's treatment wishes, stating, "[s]he is, after all, a child. She is 12" at para 89).

162 Michael Freeman, "Taking Children's Rights More Seriously" (1992) 6:1 Intl JL Pol'y & Fam 52 at 66.

163 Mona Paré, "Of Minors and the Mentally Ill: Re-Positioning Perspectives on Consent to Health Care" (2011) 29:1 Windsor YB Access Just 107 at 114.

164 Archard & Skivenes, "Hearing the Child", *supra* note 151 at 394.

vacuum. Children are also granted less latitude for mistakes. But as others have pointed out, the right to self-determination includes the right to make mistakes, especially where those mistakes are not likely to cause death or serious harm.[165]

There are also practical reasons to defer to a capable child's treatment wishes. Parenting disputes involving capable children form part of the "vast majority" of cases that the Supreme Court said belong in a doctor's office, not a court.[166] This is certainly true for cases, like *A.B. v. C.D.*, where a capable child consents to treatment recommended by a healthcare provider. But it also extends to cases where a capable child refuses treatment. In many jurisdictions, a family court order directing treatment of a capable child may be futile. As the Court of Appeal for Ontario recognized in *A.M. v. C.H.*, treatment providers cannot treat a capable person without their consent.[167] In addition to contravening health law statutes, treatment without consent is tortious and criminal.[168]

Family court intervention may be appropriate where there is a parental dispute over treatment of an *incapable* child or there is a legitimate question about the child's capacity. In these cases, a court may determine whether a particular treatment is in the child's "best interests." Rather than direct that treatment occur,[169] a court should grant medical decision-making responsibility—in whole or in part—to one parent. This allows treatment providers to independently assess the child's capacity and comply with laws around informed consent.

Family courts should consider an *incapable* child's autonomy when determining whether a particular treatment is in their best interests. At a

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165 Ronald Dworkin, *Taking Rights Seriously* (London, UK: Duckworth, 1977) at 188–89. Freeman relies on Dworkin to make this point about children's decision-making (Freeman, "Whither Children", *supra* note 146 at 323). I am not suggesting that a child refusing life-saving treatment would always be making a mistake.

166 *AC*, *supra* note 38 at para 85.

167 *AM*, *supra* note 2 at 72.

168 *Toews*, *supra* note 12. Treatment without consent may be a criminal assault (see *Criminal Code*, RSC 1985, c C-46, s 265).

169 For an example of where a court directed treatment, see *Malhotra*, *supra* note 114 at para 183, affirmed in *AM*, *supra* note 2 at para 46. The order in *PR* also comes close by requiring the father to file proof of vaccination with the court (*supra* note 1 at paras 75–76).

minimum, this would involve hearing the child's views and registering these as one legitimate perspective on the child's best interests.[170] It could also mean respecting an incapable child's treatment wishes even where they conflict with what others would see as their best interests.[171]

Deferring to the treatment wishes of an incapable child respects their present autonomy. As David Archard has noted, there are gradations of maturity.[172] The legal standard of capacity tends to treat children who fall below this standard as lacking maturity when in fact they simply have less maturity than those who meet it.[173] In other words, children still have autonomy interests even if they cannot exercise autonomy fully or independently. This is expressed by Johan Bester who, writing about paediatric patients, notes that, "it is a unique kind of harm to impose things that are contrary to a patient's wishes and values."[174]

Respecting a child's wishes may also foster future autonomy. Scholars have suggested that autonomy must be learned through practice, and that adults have an obligation to facilitate children's development into autonomous beings. For example, Hugh LaFollette suggests that, "[w]e must train children to become autonomous, and that requires, among other things, that we treat them in some respects as if they were already autonomous."[175] Similarly, Archard argues that, "[g]iving children the

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170 See David Archard & Marit Skivenes, "Balancing a Child's Best Interests and a Child's Views" (2009) 17 Intl J Child Rts 1 ("it could be that [a child's views] matter just because they are the child's own views and because any court (or forum) making a decision about a child's future ought to take account of what the child herself thinks" at 18) [Archard & Skivenes, "Balancing a Child's Best Interests"].

171 A court's failure to order or to pause a child's treatment is not necessarily the end of the treatment discussion. Children (and parents) may change their minds.

172 Archard, *supra* note 150 at 12.

173 *Ibid*.

174 Johan Christiaan Bester, "The Best Interests Standard and Children: Clarifying a Concept and Responding to Its Critics" (2019) 45:2 J Medical Ethics 117 at 118.

175 Hugh LaFollette, "Circumscribed Autonomy: Children, Care, and Custody" in Uma Narayan & Julia J Bartkowiak, eds, *Having and Raising Children: Unconventional Families, Hard Choices, and the Social Good* (University Park, Pa: Penn State University Press, 1999) 137 at 139. John Eekelaar's model of "dynamic self-determinism" also emphasizes the importance of allowing children to make choices to prepare them for fully autonomous decision-making as adults (see Eekelaar, *supra* note 150 at 53). This account is similar to Freeman's notion of "liberal paternalism" (see Freeman, *Rights and Wrongs*, *supra* note 150 at 57–60).

freedom to make some choices is essential if they are to learn what it is to make choices and why it matters to be able to do so."[176] Tamar Schapiro elevates this recommendation to a duty, claiming that, "in order not to abuse our privilege as adults, we must make children's dependence our enemy."[177] We do this by listening to children's views and by granting them "the opportunity to make decisions in limited ways wherever possible."[178]

For incapable children, autonomy must be balanced against other "best interests" factors. Thus, Freeman concedes: "We cannot allow children the autonomy to indulge in actions or activities which will irreparably damage their full lives as adults."[179] But this balancing should not automatically subordinate autonomy to other factors; children's autonomy must be taken seriously. This includes allowing children to sometimes make what others perceive as "mistakes." Choosing unwisely is part of learning how to choose. So long as the choice does not present a significant threat to the child's life or health—in which case child protection intervention would be appropriate—perhaps the choice ought to stand. Moreover, courts should be careful about assuming a child is choosing unwisely. This is especially true where the choice conflicts with family law objectives. As Archard and Marit Skivenes point out, these objectives change.[180] Finally, any "best interests" determination should consider the costs of overriding a child's treatment wishes. This includes not only considering the emotional harm that may result from forced treatment,[181] but also any injury to the child's developing autonomy.

Courts should also be careful about importing extraneous factors into the "best interests" test. For example, vaccine refusal is complicated

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176 Archard, *supra* note 150 at 74.

177 Tamar Schapiro, "What is a Child?" (1999) 109:4 Ethics 715 at 737 [references omitted].

178 *Ibid* at 736.

179 Freeman, "Whither Children", *supra* note 146 at 324–25.

180 Archard & Skivenes, "Balancing a Child's Best Interests", *supra* note 170 at 7. The 2021 amendments to the *Divorce Act* replaced the "maximum contact principle" with the "parenting time factor" to signal that maximum time with a parent is not always in a child's best interests (see *Barendregt v Grebliunas*, 2022 SCC 22 at para 135). We may one day come to view as sensible a child's refusal to attend "reunification therapy" with a parent they do not wish to see.

181 See *OMS* CA, *supra* note 1 at para 80.

by third party impacts: Children who refuse vaccines may endanger themselves *and others*. The same is true for adults who refuse vaccination. The effect of non-vaccination on third parties may require a different balancing of rights.[182] However, this does not mean the burden of protecting others should fall disproportionately on vaccine-hesitant children. We should be wary of sacrificing children's interests in autonomy and bodily integrity to protect those of adults.

Finally, in deciding whether a child's treatment wishes conflict with their best interests, family courts should give significant weight to the opinions of professionals who know the child. To prevent courts from judging a child's maturity based on the child's wishes, it may be important for a professional to evaluate the child's maturity, and a court to determine best interests.[183] Disaggregating maturity and best interests may guard against what Justice Abella identified as the "indiscriminate application of judicial discretion" that can plague these cases.[184] It is concerning that in several of the cases surveyed, courts ignored or rejected reports of professionals testifying to the child's maturity without the court ever having met the child.[185]

CONCLUSION

Canadian family courts take different approaches to resolving parental disputes over children's treatment. While some courts apply health law

182 For a text that suggests ways to limit vaccine exemptions to promote public health goals, see Mariette Brennan, Kumanan Wilson & Vanessa Gruben, "Mandatory Childhood Immunization Programs: Is There Still a Role for Religious and Conscience Belief Exemptions?" (2021) 58:3 Alta L Rev 621 at 623.

183 Archard and Skivenes identify "an evident problem in having the same experts who judge what is in the child's best interests also judge the weight that should be given to the child's own contrary judgement" (see Archard & Skivenes, "Balancing a Child's Best Interests", *supra* note 170 at 9).

184 *AC*, *supra* note 38 at para 91.

185 See e.g. *Malhotra*, *supra* note 114 at paras 150–151, affirmed in *AM*, *supra* note 2 at para 75. See also *JN* CA, *supra* note 1 at paras 32–36, where the Court of Appeal for Ontario overruled the trial judge's finding that the children were sufficiently mature—a finding that was supported by the children's lawyer. Ideally, children could be supported in their medical decision-making through a more formal process. For example, Paré has argued in favour of a model of supported decision-making for incapable patients, including minors (see Paré, *supra* note 163 at 125).

or draw on its fundamental principles, most rely exclusively on family law and its "best interests of the child" standard. These cases raise familiar questions about how to balance children's welfare and autonomy. But they also raise new questions about the proper role of family courts in children's treatment decisions. To reconcile the apparent tension between family law and health law in these cases, I have advocated taking children's autonomy seriously. For capable children, this means allowing treatment decisions to be made in the offices of treatment providers, not courts. For incapable children, it means recognizing developing autonomy as a significant factor in determining whether it is in a child's "best interests" to override their treatment wishes and sometimes allowing them to make "unwise" choices. At the very least, children's views need to be heard and seriously considered.