• RECENT CASE REGARDING PARENT REFUSING CHEMOTHERAPY FOR FIRST NATIONS CHILD IN FAVOUR OF TRADITIONAL MEDICINES: WHAT ARE THE IMPLICATIONS FOR HEALTH CARE PROVIDERS? •

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Background

J.J., an 11-year-old Mohawk girl, was diagnosed with acute lymphoblastic leukemia ("ALL"). J.J.'s mother, D.H., is her substitute decision maker ("SDM"). With chemotherapy, J.J. was assessed to have 90%–95% probability of survival. To date, paediatric oncologists are not aware of any child with ALL who survived without chemotherapy. J.J. was treated with chemotherapy for a number of days before her mother withdrew consent, having decided that she wanted to pursue traditional aboriginal medicine to treat her daughter's cancer.

A report was made by the paediatric oncologist to the local children's aid society (the "CAS"), Brant Family and Children's Services, as it was believed that this child was in need of protection. The Brant CAS decided not to intervene, which led the Hospital to bring an application under the *Child and Family Services Act* [*CFSA*][1] to try to compel the CAS to intervene such as to bring the child back into chemotherapy treatment as soon as possible. Brant CAS opposed that application, as did the Six Nations Band, for different reasons. On the first day of the hearing of the application, Justice Edward issued an order that the child not be removed from Ontario without further order of the court; however, the child's mother took her to Florida that same day to attend an alternative treatment facility, and the hearing proceeded in their absence.[2]

What the Decision Determined

There are essentially two different parts to the decision: the first dealing with the important process issues as between the Hospital and the CAS, and the second with the constitutional law and aboriginal rights issues raised by the Band. The Hospital was wholly successful in respect of the first part of the decision.

1. The Process Issues. The CAS tried to argue that this was not a child protection case, because the mother was not "refusing treatment" but, rather, was opting for another form of treatment with which the physicians disagreed. Hence, they argued that whether or not the mother's decision was in the best interests of the child was a *Health Care Consent Act* [*HCCA*][3] issue that the physicians ought to have brought before the Consent and Capacity Board (the "CCB") for a determination, not to the CAS and/or to the court under the *CFSA*. They also argued that there was insufficient evidence that the child was not capable of making her own decisions with respect to the treatment of her leukemia. These arguments were unconnected to the First Nations status of the family.

Justice Edward rejected the CAS arguments and accepted that the mother's decision to discontinue

chemotherapy is a child protection issue and that its proper adjudication was before the Ontario Court of Justice under the *CFSA*. This included a finding by the court confirming that the child was incapable of making her own decision to refuse chemotherapy. He accepted the medical evidence as to chemotherapy's effectiveness and acknowledged the absence of evidence as to the efficacy of the alternative and traditional medicines.

Because of what the judge went on to decide, he stopped short of finding that in fact this child was in need of protection for no expressed reason other than the fact that her mother was making decisions in accordance with her native Mohawk culture. He did not engage in an analysis of what is in the best interest of J.J., the test usually applied in child protection cases.

2. The Aboriginal Rights Issue. Justice Edward found that the practice of traditional medicine forms an integral element of the Six Nations' (the band to which J.J.'s family belongs) culture and that J.J.'s mother was deeply committed to her aboriginal culture and the practice of traditional medicine. He found that the decision to pursue aboriginal medicine for J.J. is her mother's constitutionally protected right pursuant to s. 35 of the *Constitution Act*, *1982*,[4] which is not subject to any limitations, reasonable or otherwise.

It is only with respect to the second issue—the court's considering only the mother's rights and not the child's best interests—that most legal commentators question the Edward J.'s unprecedented decision.

It is anticipated that in this or future cases, this Edward J.'s views on this aboriginal right will be challenged in higher courts. It will be argued that even if the pursuit of traditional medicine is an aboriginal right recognized and affirmed by s. 35 of the Constitution, it is subject to reasonable limits such that it cannot be used to trump an incapable person's right to life or the protections under the *CFSA* afforded to a child in need of treatment.

In the meantime, the following are some guiding principles for health care providers:

- The constitutional right which has been protected and affirmed in this case is solely that of an aboriginal person to practise traditional medicine. It does not address any other situation.
- It remains the case that where a parent is refusing required medical treatment for an incapable child under the age of 16, this is a matter which is reportable to the CAS. We believe that this is still the case, even for First Nations children. The CAS, working collaboratively with the health care team, should carefully investigate the alternative treatment plan to ascertain that it is actually rooted in the exercise of an aboriginal right. In our opinion, it would be wrong to assume that just because a child is a member of a First Nations family, a parent's refusal of required treatment does not trigger the threshold duty to report the situation to the CAS. It is also not correct for a CAS to suggest that it has no role in these matters or that the CCB has primary jurisdiction.

- When a parent refuses or withdraws consent to a required treatment, it is wise to ensure that there is clear documentation of the determination, formal or informal, of the child's capacity or incapacity to make the decision, even where it is otherwise obvious.
- In cases where the incapable person is an adult age 16 or over, and their SDM is refusing required medical treatment, a health care practitioner should still consider an application to the CCB if this decision is thought to be contrary to the patient's prior capable wish or, in its absence, the patient's best interests (which includes a consideration of the patient's values and beliefs). Where the SDM's decision is based, however, on a choice to pursue aboriginal traditional medicine, we can anticipate that the CCB would be cautious in light of Edward J.'s decision.

The bottom line is that this decision does not change the obligations of health care providers. If a physician believes that the treatment decisions of an SDM places a child at medical risk (*i.e.*, in need of protection), he or she has the obligation to make a report to the CAS. At that point, it is the responsibility of the CAS, as always, to conduct an investigation to determine whether the child is in need of protection and to bring the matter before the court if appropriate. Justice Edward's decision essentially affects the decision(s) the CAS may come to only if the child's family is aboriginal and the SDM is opting out of the physician's proposed treatment plan to pursue traditional aboriginal medicine.

It is too early to say for how long Edward J.'s decision on the aboriginal rights issue will stand. Stay tuned for further developments.

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1 R.S.O. 1990, c. C.11.

2 *Hamilton Health Sciences Corporation v. D.H.*, [2014] O.J. No. 5419, 2014 ONCJ 603.

3 S.O. 1996, c. 2, Schedule A.

4 R.S.C. 1985, App. II, No. 44, Schedule B.

• SASKATCHEWAN EMPLOYEE SNOOPING CASE: DO TWO PRIVACY WRONGS MAKE A RIGHT? •

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In November 2014, the Saskatchewan Information and Privacy Commissioner ("SIPC") issued an Investigation Report (No. 088/2013)[1] in a case involving employee "snooping" in personal health records held by the Regina Qu'Appelle Regional Health Authority (the "RQRHA"). The case raises interesting questions about how far a public body should go to prevent future snooping incidents.

The case involved a doctor who had viewed the health records of a nurse employed by the RQRHA in 2012; the health records were stored