Physician Dismissal of Vaccine Refusers: A Legal and Ethical Analysis

*Shawn HE Harmon, David E Faour & Noni E MacDonald**

While vaccines represent one of the most effective health interventions of the twentieth-century, most vaccine-suppressed infectious diseases are merely contained within a defined geographical area for as long as preventative measures can interrupt effective transmission. A difficulty faced by public health authorities is that, once outbreaks become rare, parents of minor children who are meant to commence their scheduled vaccines may question whether vaccination is necessary. This hesitancy can be compounded, or transformed into vaccine refusal, by social circles and vaccine-negative social media campaigns. As a result, some parents refuse some or all vaccines for their children. Indeed, vaccine hesitancy and refusal have increased in the last decade. Some physicians have responded by dismissing refusers and their families from their practice. While dismissal data is not readily available for most jurisdictions, dismissal of patients is a serious and growing concern.

Alors que les vaccins représentent l'une des interventions sanitaires les plus efficaces du 20e siècle, la plupart des maladies infectieuses supprimées par un vaccin sont simplement contenues dans une zone géographique définie aussi longtemps que des mesures préventives peuvent interrompre une transmission efficace. Une difficulté à laquelle sont confrontées les autorités de santé publique est que, lorsque les épidémies deviennent rares, les parents d'enfants mineurs qui sont censés commencer leurs vaccins programmés peuvent se demander si la vaccination est nécessaire. Cette hésitation peut devenir aggravée, ou transformée en refus de vaccination, par les milieux sociaux et les campagnes sur les médias sociaux défavorables à la vaccination. En conséquence, certains parents refusent certains ou tous les vaccins pour leurs enfants. En effet, l'hésitation et le refus des vaccins ont augmenté au cours de la dernière décennie. Certains médecins ont réagi en mettant fin

* Shawn HE Harmon, BA, LLB, LLM, PhD; Health Law Institute, Schulich School of Law, Dalhousie University, Halifax, NS; Department of Paediatrics, IWK Health Centre, Dalhousie University, Halifax, NS; School of Law, University of Edinburgh, Scotland. David E Faour, BA, JD; Faculty of Medicine, Dalhousie University, Halifax, NS. Noni E MacDonald, MD, MSc, FRCPC, FCAHS; Department of Paediatrics, IWK Health Centre, Dalhousie University, Halifax, NS.

Citation: Shawn HE Harmon, David E Faour & Noni E MacDonald, "Physician Dismissal of Vaccine Refusers: A Legal and Ethical Analysis" (2020) 13:2 McGill JL & Health 255.

Référence : Shawn HE Harmon, David E Faour et Noni E MacDonald, « Physician Dismissal of Vaccine Refusers: A Legal and Ethical Analysis » (2020) 13:2 RD & santé McGill 255.

As such, this article offers an analysis of the legal and ethical implications of physician dismissal of patients for vaccine refusal, focusing on Canada, but drawing on evidence and authorities from the United Kingdom and the United States where appropriate. It concludes that, while physician dismissal of vaccine refusers is occasionally supportable, it is generally ethically and legally problematic. It closes with suggestions for physicians for managing vaccine refusal in the clinical setting.

leur relation avec les patients qui refusent les vaccins et leur famille. Bien que les données sur la fin de la relation patient-médecin licenciements ne soient pas facilement disponibles pour la plupart des juridictions, cette pratique est une préoccupation sérieuse et croissante. Par conséquent, le présent article propose une analyse des implications juridiques et éthiques de la fin de la relation patient-médecin pour refus de se faire vacciner en se concentrant sur le Canada, mais en s'appuyant sur les preuves et les autorités du Royaume-Uni et les États-Unis le cas échéant. Les auteurs concluent que, si cette pratique par les médecins est parfois justifiable, elle est généralement problématique d'un point de vue éthique et juridique. L'article propose finalement quelques suggestions pour gérer les refus de vaccins dans le cadre clinique.

Introduction

Vaccines represent one of the most effective twentieth-century advances for human health and welfare.[1] However, while some infectious diseases can be eradicated, most are merely contained or suppressed within a defined geographical area for as long as preventative measures can interrupt effective transmission.[2] This means that vaccination[3] for most infectious diseases (such as measles, pertussis, etc.) must be continued indefinitely, and certainly long after local outbreaks have become rare. One of the difficulties faced by public health authorities seeking to maintain infectious disease suppression is that, once outbreaks do become rare, patients – and, importantly, parents of minors who are meant to receive their public health recommended immunizations – may question whether vaccination is necessary or desirable. This hesitancy can be compounded, or transformed into vaccine refusal, when these individuals' social circles (physical or digital) are subtly or explicitly vaccine-negative. In such cases, their individual concerns are reinforced by those in the community who have an anti-vaccine stance.[4]

Given the above, and despite robust evidence that routine vaccination is overwhelmingly safe and effective in averting a range of infectious disease-based complications, including death, some parents refuse some or all vaccines for their children.[5] Indeed, vaccine hesitancy and refusal has increased

---

1 See generally Francis E Andre et al, "Vaccination Greatly Reduces Disease, Disability, Death and Inequity Worldwide" (2008) 86:2 Bull WHO 140 (for an overview of the diverse benefits of immunization programs).

2 See Walter R Dowdle, "The Principles of Disease Elimination and Eradication" (1999) 48:Supp Morbidity & Mortality Weekly Rep 23 at 24.

3 In immunology, a "vaccination" is the administration of a substance in order to immunize (that is, induce an immune response in) a patient. While the distinction between these two terms is meaningful in certain contexts, in this paper the terms are used interchangeably.

4 See Chris T Bauch & Alison P Galvani, "Social Factors in Epidemiology" (2013) 342:6154 Science 47 at 48; Elisa J Sobo, "Social Cultivation of Vaccine Refusal and Delay Among Waldorf (Steiner) School Parents" (2015) 29:3 Med Anthropol Q 381 at 393. See generally Sorough Vosoughi, Deb Roy & Sinan Aral, "The Spread of True and False News Online" (2018) 359:6380 Science 1146.

5 See Eve Dubé et al, "Measuring Vaccine Acceptance Among Canadian Parents: A Survey of the Canadian Immunization Research Network" (2018) 36:4 Vaccine 545 at 545.

in the last decade.[6] Once the proportion of unvaccinated individuals within a community rises above a certain threshold, which is determined by a number of social and disease-specific factors, all of those who lack individual immunity are at risk (i.e., the benefits of community immunity are lost).[7]

The public health implications of vaccine refusal are well documented. In Canada, a 2014 measles outbreak in the Fraser Valley, British Columbia, and a 2015 measles outbreak in Lanaudière, Québec, both in communities with high vaccine refusal rates, were financially costly and necessitated special administrative actions to interrupt and contain them.[8] These and similar cases demonstrate *inter alia* that the unvaccinated are often clustered and not evenly distributed across a locale, which increases the potential for outbreaks.[9] This reality, as well as the heightened potential for premature morbidity, have increased the need to stop such outbreaks.[10]

---

6 See Varun K Phadke et al, "Association Between Vaccine Refusal and Vaccine-Preventable Diseases in the United States: A Review of Measles and Pertussis" (2016) 315:11 JAMA 1149 at 1153–54; Tom Moberly, "UK Doctors Re-Examine Case for Mandatory Vaccination" (2017) 358 BMJ online. See also "Survey Raises Concern About Vaccine 'Hesitancy' Among Canadian Parents, Shows Some Harbour Misinformation", *National Post* (18 December 2015), online: <www.nationalpost.ca> [perma.cc/4JCU-6BV2]; Robert Dingwall, "Why Are Vaccination Rates in England Falling?", *The Conversation* (12 September 2016), online: <theconversation.com/why-are-vaccination-rates-in-england-falling-64931> [perma.cc/UXS6-XD89]; Rebecca Fortin & Seema Marwaha, "Canada's Vaccine Problem", *TVO Current Affairs* (5 May 2017), online: <www.tvo.org/article/canadas-vaccine-problem> [perma.cc/394E-NFUX]; Maggie Fox, "Vaccines Rates Are Up, But So Are Refusals", *NBC News Online* (18 January 2018), online: <www.nbcnews.com> [perma.cc/4J2N-6TJZ].

7 See Paul Fine, Ken Eames & David Heymann, "Herd Immunity: A Rough Guide" (2011) 52:7 Clinical Infectious Dis 911 at 911.

8 See "Measles & Rubella Weekly Monitoring Report: March 29 to April 4, 2015 (Week 13)" (4 April 2015), online: *Government of Canada* <www.canada.ca> [perma.cc/8TJC-SRW7]; Monika Naus et al, "Outbreak of Measles in an Unvaccinated Population, British Columbia 2014" (2015) 41:7 Can Commun Dis Rep 169 at 169.

9 See Philip J Smith et al, "Children and Adolescents Unvaccinated Against Measles: Geographic Clustering, Parents' Beliefs, and Missed Opportunities" (2015) 130:5 Sage Public Health Rep 485 at 500.

10 See generally David N Durrheim & Natasha S Crowcroft, "The Price of Delaying Measles Eradication" (2017) 2 Lancet Public Health 130; "New Measles

Of course, the burdens that vaccine refusers present are not limited to the health care system or the community. They represent challenges and burdens for individual physicians as well. For example, the physician may have to expend clinical time to discuss perceived and potential harms and benefits, may face conflict arising from positional vaccination discussions, and may have to take steps to alleviate the risk to other patients in the waiting room posed by the unvaccinated.[11] As a result, some physicians – in both Canada and the United States – simply dismiss refusers and their families from their practice.[12] Note this widely circulated Facebook notice by one American paediatrician:

> In my practice you will vaccinate and you will vaccinate on time. You will not get your own "spaced-out" schedule that increases your child's risk of illness or adverse event. I will not have measles-shedding children sitting in my waiting room. I will answer all your questions about vaccine and present you with facts, but if you will not vaccinate then you will leave my practice. I will file a [Child Protective Service] report (not that they will do anything) for medical neglect, too.
>
> I have patients who are premature infants with weak lungs and hearts. I have kids with complex congenital heart disease. I have kids who are on chemotherapy for acute lymphoblastic leukemia who cannot get all of their vaccines. In short, I have patients who have true special needs and true health issues who could suffer severe injury or death because of your magical belief that your kid is somehow more special than other children and that what's good for other children is not good for yours.

Surveillance Data From WHO" (12 August 2019), online: *World Health Organization* <www.who.int/immunization/newsroom/new-measles-data-august-2019/en/> [perma.cc/2XPM-4R83].

11 See Ross D Silverman & Lindsay F Wiley, "Shaming Vaccine Refusal" (2017) 45:4 JL Med & Ethics 569 at 574.

12 See Anita Li, "Pediatricians in Canada Discharging Unvaccinated Children", *The Toronto Star* (25 April 2012), online: <www.thestar.com> [perma.cc/NP4W-TV5Y]. See also Ohid Yaqub et al, "Attitudes to Vaccination: A Critical Review" (2014) 112 Social Science & Medicine 1; Catherine Hough-Telford et al, "Vaccine Delays, Refusals, and Patient Dismissals: A Survey of Pediatricians" (2016) 138:3 Pediatr 1.

> This pediatrician is not putting up with it. Never have, never will.[13]

While dismissal data is not readily available for most jurisdictions, dismissal of patients by physicians – both family physicians and paediatricians – is very likely a serious and growing concern in Canada.[14]

Given the above, this article offers an analysis of the propriety of physician dismissal of vaccine hesitant and vaccine-refusing patients, taking into account practical, ethical, and legal elements, the latter of which will loom large in the assessment. First, this paper examines the rights of patients generally and of minors (i.e., infants and children) more specifically. In doing so, it acknowledges the necessary role of parents and guardians in the health care of minors, highlighting their moral and legal rights and responsibilities in health care decision-making for minors. Second, this article examines the legal, professional, and ethical rights and duties of physicians. Having laid this necessary legal groundwork and taking the parties' rights, responsibilities, and reasonable expectations into account, it assesses the propriety of patient dismissal by physicians before offering an alternative approach to handling vaccine refusal within the clinical setting which is supportable under both legal and professional rules. This article concludes that dismissal, while occasionally legally and professionally permitted and justifiable under certain circumstances in certain jurisdictions, will not usually be ethically or legally appropriate, and should be viewed as an absolute last measure in the breakdown of the doctor-patient relationship. It also argues that either legislation or provincial codes, or both, should offer clearer guidance as to when dismissal is justified, bearing in mind the countervailing rights of patients.

---

13 See Maria Guido, "Pediatrician's Message Goes Viral: 'In My Practice You Will Vaccinate and You Will Vaccinate On Time'" (20 April 2017), online (blog): *Scary Mommy* <www.scarymommy.com> [perma.cc/K9SN-27G9].

14 See Noni E MacDonald et al, "Is Physician Dismissal of Vaccine Refusers an Acceptable Practice in Canada? A 2018 Overview" (2019) 24:2 Paediatr & Child Health 92 at 95; Beth Halperin et al, "When is it Permissible to Dismiss a Family Who Refuses Vaccines? Legal, Ethical and Public Health Perspectives" (2007) 12:10 Paediatr & Child Health 843.

I. The Legal and Moral Landscape for Patients

A. The right to health and health care

Summary: Despite the international characterization of health care as a human right, there is no constitutional right to health or health care in Canada.

Health has long been constructed as a right held by all people. The foundation for this proposition is the *Constitution of the World Health Organization*, which proclaims health to be a "fundamental right,"[15] and article 25 of the *Universal Declaration of Human Rights*, which states:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[16]

It has also been re-stated in a number of binding international treaties, including the *International Covenant of Economic, Social and Cultural Rights*[17] and the *Convention on the Rights of the Child*[18], both of which are widely ratified. Multiple international legal and policy instruments reiterate this position.[19] Indeed, while the World Health Organization (WHO) has

---

15 *Constitution of the World Health Organization*, 22 July 1946, 14 UNTS 185 (entered into force 7 April 1948) at 186.

16 *Universal Declaration of Human Rights*, 10 December 1948, UN Res 217 A (III) 71, art 25.

17 *International Covenant of Economic, Social, and Cultural Rights*, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), art 11 [*ICESCR* 1966].

18 *Convention on the Rights of the Child,* 20 November 1989, 1557 UNTS 3 (entered into force 2 September 1990), art 24 [*CRC* 1989].

19 See e.g. *International Convention on the Elimination of All Forms of Racial Discrimination*, 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969), art 5; World Health Organization & UNICEF, *The Declaration of Alma-Ata*, International Conference on Primary Health Care, 12 September 1978, art 1; World Health Organization, *The Ottawa Charter for Health Promotion*, International Conference on Health Promotion, Ottawa, 21 November

emphasized that a strong health care system is an essential element of a healthy and equitable society, key to achieving the Sustainable Development Goals,[20] it has lamented that too many health care systems are inequitable, regressive, unsafe, and failing.[21]

Of course, one must be cautious about claiming an absolute "right to health"[22] for it is a right that the law does not have the authority to provide. It is rather a right to access the highest attainable standard of physical and mental health that can be achieved within the confines of the health care system in place and the resources available.[23] In any event, such a right,however constructed, is now contained in many national constitutions.[24] These rights are often supplemented by, or interpreted in line with, a range of international and local patient-oriented policies and declarations, such as judicial enforcement of access to medicines.[25]

1986 at 1; World Health Organization, *The Bangkok Charter for Health Promotion in a Globalised World*, 11 August 2005.

20 See Marie Paule Kieny et al, "Strengthening Health Systems for Universal Health Coverage and Sustainable Development" (2017) 95 World Health Org Bull 537 at 537–39.

21 See World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*: *WHO's Framework for Action* (Geneva: World Health Organization 2007) at 1.

22 See Phillip Alston, "Out of the Abyss: The Challenges Confronting the New UN. Committee on Economic, Social and Cultural Rights" (1987) 9:3 Hum Rts Q 332 at 367; F Michael Willis, "Economic Development, Environmental Protection and the Right to Health" (1996) 9 Geo Intl Envtl L Rev 195 at 196.

23 See *General Comment 14*: *The Right to the Highest Attainable Standard of Health*, CESCROR, 22nd Sess, Supp No 14, UN Doc E/C.12/2000/4 (2000) (for a fairly robust understanding of the right).

24 See Eleanor D Kinney & Brian Alexander Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World" (2004) 37:2 Cornell Intl LJ 285 at 287. See also UN High Commission for Human Rights, *The Right to Health: Fact Sheet No. 31* (Geneva: UNHCHR, 2008) at 10.

25 See Hans V Hogerzeil et al, "Is Access to Essential Medicines as Part of the Fulfilment of the Right to Health Enforceable Through the Courts?" (2006) 368:9532 Lancet 305 at 305; Jerome Amir Singh, Michelle Govender & Edward J Mills, "Do Human Rights Matter to Health?" (2007) 370:9586 Lancet 521 at 523.

In Canada, national health care policy has long been to protect, promote, and restore the physical and mental well-being of residents, and to facilitate reasonable access to health services without financial or other barriers.[26] Nonetheless, the starting point for most courts called upon to adjudicate health care claims is that there is *no* right to health care under the *Canadian Charter of Rights and Freedoms*[27] (*Charter*). This was stated in *Chaoulli v Quebec (AG)*[28], wherein Chief Justice McLachlin held that the *Charter* does not confer a free-standing constitutional right to health care.[29] Thus, although courts in other jurisdictions are more open to finding and enforcing such socioeconomic rights,[30] Canadian courts appear to take a very circumspect view of health-related rights. In *Auton v British Columbia*[31], the petitioner brought an action against British Columbia for its failure to fund applied behavioural therapy for autism, claiming a violation of section 15(1) of the *Charter*. The Supreme Court of Canada held that the benefit claimed was "not provided for by the law."[32] *The Canada Health Act* and relevant provincial legislation do not promise that a patient will receive funding for all medically-indicated treatments; rather, they confer core funding for services delivered by medical practitioners and non-core services delivered

---

26 See C*anada Health Act*, RSC 1985, c C-6, s 3 [*CHA*]. See also Canada, Royal Commission on Health Services, *Report on Health Services*, vol 1 (Ottawa: Queen's Printer, 1964) at 11–12. Pursuant to section 7 of the *CHA*, the fundamental principles underlying the national health care system are "public administration", "comprehensiveness", "universality," "portability," and "accessibility." To qualify for the full federal health care contribution, provincial health plans must satisfy these criteria, and must not allow extra billing or user fees.

27 Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

28 2005 SCC 35 at para 104.

29 See also *Baier v Alberta*, 2006 ABCA 137 at para 44, 384 AR 237, aff'd on other grounds 2007 SCC 31; *Flora v Ontario Health Insurance Plan*, 2008 ONCA 538.

30 See e.g. *Mullin v Administrator*, [1981] AIR 746, 1981 SCR (2) 516 (India); *Re Certification of the Constitution of the Republic of South Africa* [1996] CCT 23/96, 4 SA 744 (S Afr Const Ct) at para 76; *Minister of Health v Treatment Action Campaign*, [2002] CCT 9/02, ZACC 15 (S Afr Const Ct); *Tutela Decision*, [2008] T-760 (Columbia Constitutional Court), s 3.

31 [2004] 3 SCC 657 [*Auton*].

32 *Ibid* at para 35.

by accepted classes of health care practitioners.[33] Even where health care-related rights have been upheld – such as in *Eldridge v British Columbia*[34], wherein the Supreme Court held that the government's failure to provide sign language services was an infringement of section 15 equality rights under the *Charter* – implementation has been uneven and underwhelming.[35]

Parenthetically, it has been suggested that claims to positive health care rights – that is, a legal right guaranteeing that health care services will be provided – would be rightly facilitated if courts acknowledged that comprehensive and universal public health care is, in fact, the very embodiment of *Charter* values. Such a declaration would allow courts to develop precedents that offer guidance for reasonable and accountable decision making across the health care system, and would thereby counteract challenges facing the public health system.[36] This idea is further supported by the fact that legislative statements across Canada highlight shared values and expectations, including some right to quality care, respect, dignity, confidentiality, and participation in health care decision making.[37]

---

33 In *Auton*, *supra* note 31, the Supreme Court of Canada held that the legislative scheme, being a partial health plan, was not itself discriminatory in providing funding for non-core services to some groups while denying funding to others (i.e., autistic children), nor had it been established on the facts that the government excluded autistic children on the basis of disability.

34 *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624 at para 95, 151 DLR (4th) 577.

35 See Colleen M Flood & YY Brandon Chen, "Charter of Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2010) 19:3 Annals Health L 479 at 491–92.

36 See Bryan Thomas & Colleen M Flood, "Putting Health to Rights: A Canadian View on Global Trends in Litigating Health Care Rights" (2015) 1:1 Can J Comp & Contemp L 49 at 66–68. Such an approach has led UK courts to demand that decisions in the NHS meet standards of fairness and take into account all and only relevant factors. See *National Health Service Act* (UK), *2006*, c 41, s 1; *R v Secretary of State for Health*, [2017] UKSC 41 at para 96; *R v Berkshire West Primary Care Trust*, [2011] EWCA Civ 247, Med LR 226; *R v North Staffordshire Primary Care Trust*, [2011] EWCA Civ 910, Med LR 572 at para 11; *Bullmore v West Hertfordshire Hospitals NHS Trust*, [2007] EWHC 1636 (Admin).

37 See e.g. Québec's *Act Respecting Health Services and Social Services*, CQLR c S-4.2; Bill 60, *Health Charter of Rights and Responsibilities Act*, 5th Sess, 54th Leg, New Brunswick, 2003; British Columbia Health Services Administration,

B. Rights to access and to refuse treatment

Summary: Individual autonomy is the foundation of clinical care, and the right to choose between offered medical treatments, or to refuse a treatment, has been robustly upheld in Canadian law.

While there is a right – as an extension of the right to self-determination – to choose among the core medical treatments offered through the health care system, there is no right to demand a treatment that is outside good medical practice, that is viewed by the treating physician as futile, or that is not covered by the provincial insurance system.[38] In addition to these constraints, the Nova Scotia Court of Appeal has also acknowledged that health care is delivered in the context of a cap system whereby, with limited funds, the introduction of new programs can impact the amounts available for existing ones.[39] The Court held that Nova Scotia's decision not to cover in vitro fertilization was justifiable on the basis that the procedures in question, having regard to costs, limited success rates, and risks, did not rank sufficiently high to warrant payment for them.[40] More recently, in *Flora v Ontario Health Insurance Plan*[41], the Ontario Court of Appeal held that the province had no obligation to reimburse a patient under its health plan who paid out-of-pocket for a successful, lifesaving liver transplant outside of Canada after Ontario physicians determined he did not meet the local

---

Primary Health Care Charter: A Collaborative Approach (British Columbia (Ministry of Health), 2007) at 3. See also a number of bills from other jurisdictions that were never passed: Bill 18, *An Act to Promote Patients' Rights and to Increase Accountability in Ontario's Health Care System*, 3rd Sess, 36th Leg, Ontario, 1999, cl 2(1); Bill 201, *Alberta Patients' Bill of Rights*, 2nd Sess, 24th Leg, Alberta, 1998, cl 3(a); Bill C-261, *An Act to Establish the Rights of Patient in Relation to Health, Treatment and Records*, 1st Sess, 37th Parl, 2001, cl 3(a). See also Canadian Doctors for Medicare, "A Patient Bill of Rights Explored" (2011) at 1, online (pdf): <www.canadiandoctorsformedicare.ca> [perma.cc/4HVE-NNV2].

38 See *Auton*, *supra* note 31 at para 35.

39 See *Cameron v Nova Scotia (AG)* (1999), 204 NSR (2d) 1 at para 42, 177 DLR (4th) 611 (NSCA) [*Cameron*].

40 See *ibid* at para 87.

41 *Flora v Ontario Health Insurance Plan* (2008), 91 OR (3d) 412, at para 108, 295 DLR (4th) 309 (Ont CA).

criteria for the procedure.[42] In short, any positive right to access health care is limited.[43]

In contrast to their limited recognition of positive health care rights in Canada, courts have long and explicitly upheld the right of patients to refuse medical interventions. Refusal cannot be overridden, even if the treatment is deemed to be in the patient's interests or refusal is ill-advised.[44] This was clearly established as a common law right in *Hopp v Lepp*[45], and *Reibl v Hughes*[46]. It has been reaffirmed many times since,[47] perhaps most forcefully in *AC v Manitoba*, wherein Justice Abella, for the majority, held that "[t]he legal environment for adults making medical treatment decisions … demonstrates the tenacious relevance in our legal system of the principle that competent individuals are – and should be – free to make decisions about their bodily integrity."[48]

This common law right has been codified in consent-specific statutes in multiple jurisdictions[49] and is constitutionally supported by section 7 of the *Charter*, which guarantees the right to life, liberty, and security of the per-

---

42 See also *R v Parker* (2000), 49 OR (3d) 481 at para 137, 188 DLR (4th) 385 (for a discussion of access to treatment in the criminal context).

43 There are also ample UK precedents limiting the right to choose treatments. See e.g. *R v Cambridge Health Authority*, [1995] 2 All ER 129 (CA); *R v North West Lancashire Health Authority*, [2000] 1 WLR 977 (CA).

44 See *Malette v Shulman* (1990), 72 OR (2d) 417 at para 430, 67 DRL (4th) 321.

45 [1980] 2 SCR 192 at para 196, 112 DLR (3d) 67 [*Hopp*].

46 [1980] 2 SCR 880 at 39 at para 890, 114 DLR (3d) 1 [*Reibl*].

47 See generally *Pole v Region 2 Hospital Corporation* (1994), 150 NBR (2d) 366, 116 DLR (4th) 477 (NBCA). See also *Fortey (Guardian ad Litem) v Canada (AG)* (1999), 63 BCLR (3d) 185, 125 BCAC 29 (BCCA); *Starson v Swayze*, 2003 SCC 32.

48 *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para 39 [*AC*].

49 See *Health Care Consent Act*, SO 1996, c 2, Schedule A; *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181; *Care Consent Act*, SY 2003, c 21, Schedule B; *Consent to Treatment and Health Care Directives Act,* RSPEI 1988, c C-17.2; Arts 11–25 CCQ.

son.[50] The Supreme Court of Canada has suggested that the right to refuse treatment is accompanied by a corresponding right to know the risks of foregoing treatment. In *Hollis v Dow Corning Corp*, Justice La Forest stated that "every individual has a right to know what risks are involved in undergoing *or foregoing* medical treatment and a concomitant right to make meaningful decisions based on a full understanding of those risks."[51]

The question of whether material information regarding the risk of foregoing medical treatment must be provided where a patient refuses care has not been extensively considered in Canada. A brief discussion by the British Columbia Supreme Court in *obiter* appears to support a doctrine of so-called "informed refusal."[52] American jurisprudence has repeatedly upheld a physician's duty to disclose risks of foregoing a recommended medical-treatment.[53] Further, given the Supreme Court of Canada's statements that patients have a right to know the risks involved in "foregoing" treatment, held in both *Reibl*[54] and *Hollis*,[55] Canadian physicians may well be under a duty to ensure that patients have full knowledge about the risks of declining or delaying vaccinations.[56]

Ultimately, it is clear that patients have some qualified right to health, understood as a right to a reasonable level of health care generally compliant with the principles of the *Canada Health Act*.[57] Patients can access the core services and treatments provided free of cost, they can refuse any

---

50 See *Fleming v Reid* (1991), 4 OR (3d) 74 at 36, 82 DLR (4th) 298 (Ont CA). See also *Deacon v Canada (AG)*, 2006 FCA 265 at para 73; *Carter v Canada (AG)*, 2015 SCC 5 at para 66.

51 *Hollis v Dow Corning Corp*, [1995] 4 SCR 634 at para 24, 129 DLR (4th) 609 [emphasis added] [*Hollis*]. See also *Reibl*, *supra* note 46 at 894–95.

52 *Davidson v BC*, [1996] 11 BCLR (3d) 192 (SC).

53 See *Truman v Thomas*, [1980] 27 Cal 3d 285 (Cal 1980). See also *Battenfeld v Gregory*, [1991] 247 NJ Super 538 (NJ Super App Div 1991).

54 See *Reibl*, *supra* note 46 at 895.

55 See *Hollis*, *supra* note 51 at para 24.

56 See generally Gerald B Robertson & Ellen I Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters Canada, 2017) at 227–28.

57 See *CHA*, *supra* note 26, s 3.

treatment offered for any reason (or for no reason at all), and, if refusing the treatment, they are entitled to full information regarding the risks associated with their decision.

C. Minors as patients

Summary: When a child does not yet possess the legal right or ability to choose, or refuse medical treatment, parents or guardians must choose on the child's behalf, within a range of reasonable choices that support that child's best interests.

Importantly, minors have many of the same health care rights and entitlements as adults. Article 24.1 of the *Convention on the Rights of the Child* states:

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.[58]

Articles 26 and 27 build on this right by stating that children have the right to benefit from social security, and the right to a standard of living adequate for the child's physical, mental, spiritual, moral, and social development.[59] These provisions are embodied domestically in a wide range of provincial statutes relating to children and families.[60]

Of course, children are often limited in their capacity to exercise their rights because they are generally not deemed to be competent until they reach a statutorily specified age of majority (or a lower age while exhibiting an acceptable level of maturity).[61] The exact age varies from province to province, as does the maturity level required of the child. With respect to

---

58 *CRC* 1989, *supra* note 18 at 3, art 24(1).

59 See *ibid*, arts 26–27.

60 See e.g. *Child, Family and Community Service Act*, RSBC 1996, c 46. See also *Child and Family Services Act*, RSO 1990, c C-11; *Children and Family Services Act*, SNS 1990, c 5.

61 See *AC*, *supra* note 48 at paras 46, 115.

infant and early childhood immunization programs, maturity is not typically relevant to the determination, since the patient is an infant or young child reliant on others (typically his or her parents) to make decisions on his or her behalf.

By operation of long-established roles, moral obligations, and legal and constitutional rights in the parent-child relationship, parents are empowered to make decisions for their children. This right is simultaneously a moral and legal duty; parents and guardians are expected to make decisions with respect to their children's upbringing, education (including religious education), medical treatment and care, and more.[62] In other words, it is a right but also duty that they *must* discharge in support of the well-being of their children.

However, parental decision-making rights and duties are not absolute. While parents making health care decisions for their children have a certain margin of appreciation in determining the nature and scope of medical interventions, they must generally act in the child's best interests.[63] Children are widely considered to be a vulnerable group, so the decisions taken on their behalf must facilitate and safeguard their welfare.[64] This means that decisions are not to be made in furtherance of the personal desires or interests of the parent, but rather in the interests of the child. All parental decisions ought to be assessed from the perspective of the *child's* interests and welfare.[65] The child's perspective and desires become more and more important

---

[62] See *CRC* 1989, *supra* note 18, art 5.

[63] See generally *Young v Young*, [1993] 4 SCR 3, 108 DLR (4th) 193. See also *P(D) v S(C)*, [1993] 4 SCR 141, 108 DLR (4th) 287.

[64] See Loretta M Kopelman, "Using the Best-Interests Standard in Treatment Decisions for Young Children" in Geoffrey Miller, ed, *Pediatric Bioethics* (Cambridge, UK: Cambridge University Press, 2010) 22 at 23–37. See also Elizabeth S Scott & Robert E Scott, "Parents as Fiduciaries" (1995) 81 Va L Rev 2401 at 2401–76; Matthew Clayton, "How Much Do We Owe to Children?" in Sarah Hannan, Samantha Brennan & Richard Vernon, eds, *Permissible Progeny? The Morality of Procreation and Parenting* (Oxford: Oxford University Press, 2015) 246 at 250.

[65] See *B v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315 at 320, 383, 122 DLR (4th) 1. For a discussion of the "best interests" test, see *E v Eve*, [1986] 2 SCR 388 at 422–25, 31 DLR (4th) 1 [*Eve*].

– to the point of determinative – as the child matures, despite the fact that he or she may not be at the age of majority.[66]

This transition of authority, and change in role of the parent, was aptly described in *Van Mol v Ashmore*, wherein the British Columbia Court of Appeal held:

> At common law, without any reference to statute law, a young person, still a minor, may give, on his or her own behalf, a fully informed consent to medical treatment if he or she has sufficient maturity, intelligence and capability of understanding what is involved in making informed choices about the proposed medical treatment. If a young person does not have that degree of maturity, intelligence, and capability of understanding, then that young person cannot give informed consent to proposed medical treatment, and the consent must be given by a parent or guardian. But once the required capacity to consent has been achieved by the young person reaching sufficient maturity, intelligence and capability of understanding, the discussions about the nature of the treatment, its gravity, the material risks and any special or unusual risks, and the decisions about undergoing treatment, and about the form of the treatment, must all take place with and be made by the young person whose bodily integrity is to be invaded and whose life and health will be affected by the outcome. At that stage, the parent or guardian will no longer have any overriding right to give or withhold consent. All rights in relation to giving or withholding consent will then be held entirely by the child. The role of the parent or guardian is as advisor and friend.[67]

Of course, as noted above, minors who are meant to commence their infant immunization schedule cannot make decisions for themselves. As such, parents must make the decision whether or not to vaccinate. In doing so, they must be guided by the best interests of the child, as determined by all the circumstances.

A failure by the parent(s) to pursue the medical best interests of the child may lead to intervention by authorities under the relevant child wel-

---

66 See *JCS v Wren* (1987), 35 DLR (4th) 419 at paras 16–17, 76 AR 115.

67 *Van Mol (Guardian ad Litem of) v Ashmore* (1999), 168 DLR (4th) 637 at para 75, 58 BCLR (3d) 305.

fare legislation.[68] For example, in *AC v Manitoba*, Justice Abella characterized the best interests of children as a goal that is the responsibility of all of society to secure.[69] Her judgement drew on a number of principles enumerated in Manitoba's *Child and Family Services Act*, namely that the safety, security, well-being, and best interests of children are fundamental responsibilities of society and that families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.[70] Ultimately, when parents fail to take appropriate decisions for their children, or are in conflict over the best decision to make, public bodies and courts have an obligation to assess and advance the best interests of the child.[71]

D. Conflicts in the immunization context

Summary: In disputes between parents who disagree about immunization, courts usually take notice of the prevailing evidence-based public policy and award decision-making authority to the pro-immunization parent.

---

[68] See *Hamilton Health Sciences Corp v DH*, 2014 ONCJ 603 at 83, 123 OR (3d) 11.

[69] See *AC*, *supra* note 48. For a more detailed discussion of this case, see Shawn HE Harmon, "Body Blow: Mature Minors and the Supreme Court of Canada's Decision in AC v Manitoba" (2010) 4:1 McGill JL & Health 83 at 83–96.

[70] See *The Child and Family Services Act*, SM 1985, c 8, CCSM c C-80, s 1.

[71] In this regard, see *CRC* 1989, *supra* note 18, art 3, which states:

> 1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
>
> 2. Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
>
> 3. Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Courts in Canada retain a *parens patriae* (literally, "parent of the nation") jurisdiction to act, unilaterally if necessary, to protect vulnerable persons.[72] In the vaccination context, courts have exercised this authority with respect to childhood immunizations, and vaccines have even been ordered *against* the wishes of a parent. For example, in *Chmiliar v Chmiliar*[73], the custodial parent refused to vaccinate her children despite a request by the other parent that they be vaccinated, and despite a meningitis outbreak in the region. The Court of Queen's Bench of Alberta ordered the ten-year-old son to be vaccinated but, influenced by its view that the children's lives were not immediately threatened, declined to order the thirteen-year-old daughter to be vaccinated, noting that she was a mature minor capable of making her own decision.[74] In *MJT v DMD*[75], the British Columbia Supreme Court gave the parents joint decision-making authority in relation to the child's welfare, but found that vaccination was in the child's best interests and granted sole vaccination decision-making authority to the father, who supported vaccination. Similarly, in *GM v SS*[76], the British Columbia Supreme Court found that one parent was better able to make well-researched, evidence-based decisions about the child's health care, so it gave that parent authority over the child's medical care, including vaccinations and choice of physician.

In *CMG v DWS*[77], divorced parents had agreed that they would not vaccinate their child until she turned twelve, at which time she could choose for herself. The custodial mother sought to take the child (still only ten years old) on a trip to Germany. The father insisted that she be vaccinated. On the parents' initial approach to vaccination, the Ontario Court of Justice observed as follows:

---

72 See *Eve*, *supra* note 65 at paras 31–55 (for a discussion of the development of the *parens patriae* jurisdiction in the United Kingdom and Canada).

73 2001 ABQB 525.

74 *Ibid* at para 31.

75 2012 BCSC 863 at para 228.

76 2012 BCSC 1491 at para 93. Indeed, in most cases where the parents are at odds over vaccination, it is the vaccine-supporting parent who is given ultimate medical decision-making authority, or, more narrowly, vaccine-acceptance decision-making authority, see e.g. *TF v AD*, 2013 BCPC 205 at paras 46–47.

77 2015 ONSC 2201 [*CMG*].

> The parents' absolute prohibition on vaccinations for the child prior to age 12, in my view, is not in the best interests of the child. That agreement of the parents does not reflect any reasoned analysis that is required in order to make a decision to vaccinate or not vaccinate the child. It does not deal with any reasoned consideration of issues that may arise in the future. It represents a simple ban of vaccinations where a complex analysis is required. I accept the evidence of the father that that agreement represented a simple way to end the litigation rather than deal with the disputed issues. In my view, a joint custody scheme that is entered into on the basis does not reflect the legal considerations that are clearly set out by many courts.[78]

On the mother's evidence in support of her decision to refuse vaccinations for her daughter – which included affidavits from a naturopath and a chiropractor – the Court held:

> The above list of "indisputable facts" that are set out by the mother, in my view, demonstrates her lack of objectivity and thoroughness of research. She offered no evidence that the claims set out above are "indisputable facts supporting her decision not to vaccinate." Far from being indisputable facts, I find that they are rigidly held beliefs of the mother and others who support her that are not supported in the scientific community.
>
> I find that the mother and her supporting witnesses are locked in a never ending spiral of blind acceptance of statements by individuals who claim to be experts in the field in which they are not. The mother accepts many of their statements about the state of the research and like the alleged experts who filed evidence on her behalf; she passes these beliefs on as if they are legitimate studies that have received general acceptance. Most of the supporting research offered by the mother and her supporters is not valid and does not consider objective facts, research and literature that are thorough and peer reviewed. Counsel for the mother submitted that the present hysteria around measles and vaccinations is something that is a creation of the media and not grounded in fact and research. I strongly disagree.[79]

---

78 *Ibid* at para 38.

79 *Ibid* at paras 64–65.

In its judgement, the Court ordered that it was in the child's best interests to be vaccinated, in keeping with Ontario and Canadian public policy relating to the health of children and the public, and in keeping with the WHO's position on public health and safety.[80] The Court also ordered the mother not to communicate with the child in a manner that would be negative to the child receiving the vaccinations.[81]

In keeping with *CMG v DWS*, the Ontario Superior Court of Justice in *De Serio v De Serio*[82] similarly rejected a range of vaccine-negative evidence that one parent had relied on, noting that it was comprised of a variety of largely unscientific and opinion-based evidence of no value, and could be afforded no weight. More recently, in *PW v CM*[83], the Nova Scotia Supreme Court again rejected the evidence of a vaccine-refusing parent and gave sole medical decision-making authority to the other parent.

E. The patient context summarized

Patients, whether adults or minors, have the right to equitably access health services provided through the Canadian health care system. Given the status of minors, parents have rights in respect of their children, and are *entitled* to make health care decisions for their children. These rights are also clearly duties. Thus, it is equally true that parents have a *responsibility* to make decisions for their children. This duty requires that parents' health care decisions must advance the welfare of their children (i.e., decisions must be made in the child's best interests). While the state does not scrutinize the minutiae of every decision, decisions can be examined in cases of parent-parent, parent-practitioner, or parent-child conflict. In such cases, the courts, exercising their *parens patria* jurisdiction, will identify what those "best interests" are, and will make a determination as to the means of best achieving them.

In addition to this landscape of rights and duties, the reality of the Canadian health care system must be taken into account. Immunization programs are properly viewed as key governmental mechanisms for realizing

---

80 See *ibid* at para 105.

81 See *ibid* at para 108.

82 [2002] OJ No 5341 at para 25, 27 RFL (5th) 38.

83 2017 NSSC 91 at para 139.

the right to reasonable health care. That being said, the Canadian health care setting is one of the most complex in the world,[84] which makes it difficult for public health frameworks to effectively deliver uniform programs to their intended populations. For example, Nova Scotia delivers its immunization programs largely through physicians' offices,[85] while Alberta delivers them through bespoke public health structures.[86] And while immunization is largely voluntary in Canada, different programs have different elements that might be characterised as "mandatory". For example, in Nova Scotia, children must provide their immunization records in order to attend preschool,[87] while in Ontario and New Brunswick, proof of immunization is needed for school attendance, although opt-out provisions are available.[88] This diversity of vaccine delivery methods and vaccine requirements, combined with rights to refuse treatment, can permit potentially harmful gaps in coverage, which must, wherever possible, be minimized.

---

84 See Danielle Martin et al, "Canada's Universal Health-Care System: Achieving its Potential" (2018) 391:10131 *Lancet* 1718.

85 See Government of Nova Scotia, *Nova Scotia Immunization Manual* (July 2019) at 2, online (pdf): <www.novascotia.ca/dhw/cdpc/documents/immunization-manual.pdf> [perma.cc/3LNJ-J9B7].

86 See "Where to Immunize" (last visited 2 February 2020), online: *Alberta Health Services* <immunizealberta.ca/i-want-immunize/where-immunize> [perma.cc/SHH5-PZ5D].

87 See NS Reg 193/2010, s 31(d), as amended by NS Reg 36/2017. By operation of the *Health Protection Act*, SNS 2004, c 4, the *Day Care Act*, RSNS 1989, c 120, and the Nova Scotia, *Guidelines for Communicable Disease Prevention and Control for Child Care Settings* (Nova Scotia, 2014), a day-care operator or director must report any child or staff believed to have a notifiable disease. Notifiable diseases include communicable diseases on the provincial immunization schedule. The Medical Officer of Health can then prohibit or exclude a person from the program who has a communicable disease, has symptoms of a communicable disease, or has been in contact with a person having a communicable disease.

88 With respect to Ontario, see O Reg 137/15, s 35(1) under the *Child Care and Early Years Act*, SO 2014, c 11, Schedule 1. Under this Act, the pupil's parent must cause the pupil to complete the prescribed program of immunization in relation to each of the diseases designated by the Act. Failure to do so can result in suspension of the student, and a fine for the parent. With respect to New Brunswick, see *Public Health Act*, SNB 1998, c P-22.4, s 42.1.

In cases of parental conflict over health care decision making relating to immunization, the following observations can be made:

- In making health-related "best interests" decisions, courts are influenced by public health policies and immunization programs crafted by public health authorities, and by health policy and technical advice proffered by the WHO, all of which strongly favour immunization.[89]

- Courts are generally reluctant to order the vaccination of children,[90] preferring instead to keep the power and responsibility with one or both of the parents, so long as one of them demonstrates an ability to be rational and reasonable.

Given the well-entrenched rights of children to protection and to adequate health care, and given the proven utility of vaccination both to individuals and communities,[91] Canadian children might *expect* to benefit from immunization programs, and parents should rightly have to meet a high threshold in making a case that routine vaccination is *not* in the child's best interests.[92] In situations of conflict, that case will be made before a court. In

---

89 See *CMG*, *supra* note 77 at para 105.

90 But see *Children's Aid Society of Peel Region v H (TMC)*, 2007 ONJC 632 at para 14 (wherein the Ontario Superior Court of Justice ordered a vaccination over the objections of both parents).

91 See Francis E Andre et al, "Vaccination Greatly Reduces Disease, Disability, Death and Inequity Worldwide" (2008) 86:2 WHO Bull 140 at 141; Marc Brisson & John Edmunds, "Economic Evaluation of Vaccination Programs: The Impact of Herd-Immunity" (2003) 23:1 Medical Decision Making 76 at 76. See also Government of Canada, "Vaccines for Children: Deciding to Vaccinate" (last modified June 2019), online: *Government of Canada* <www.canada.ca/en/public-health/services/vaccination-children.html> [perma.cc/JB9S-UQTW]; "Why Vaccination is Safe and Important?" (last modified July 2019), online: *NHS Choices* <www.nhs.uk/conditions/vaccinations/reasons-to-have-your-child-vaccinated/> [perma.cc/N575-9S5W]; "Five Important Reasons to Vaccinate Your Child" (last modified January 2018), online: *US Health and Human Services* <www.vaccines.gov/getting/for_parents/five_reasons/index.html> [perma.cc/EM92-FT7W].

92 However, note that courts generally impose a relatively high threshold of potential harm to the child before it will intervene against the wishes of parents in agreement. See *CRB v Newfoundland and Labrador (Director of Child Welfare)* (1995), 137 Nfld & PEIR 1 at para 5, 1995 CanLII 10584 (NL SC) (faced with religious objections to the vaccination of three children, the Court found

the absence of conflict, parents are largely unencumbered in refusing vaccinations for their children because, as noted, most Canadian immunization programs are voluntary. Nevertheless, calls have been made to hold refusers legally liable for harm caused to others by their decision.[93]

II. The Legal and Regulatory Landscape for Physicians

Perhaps unsurprisingly, physicians have both legal and ethical duties in relation to the care to their patients. Physicians have a complex array of competing interests, rights, and obligations to balance with respect to their interactions with patients.

A. Physician duties to patients and the public

Summary: Physicians owe both legal and ethical duties to their patients and to society at large. Encouraging patients to accept vaccination is almost certainly both legally and ethically required.

From a legal perspective, once a doctor-patient relationship exists, the physician owes the patient a duty of care. The duty of care requires that physicians exercise reasonable and ordinary care and skill, as the average health care provider would under similar circumstances.[94] Under tort law, physicians can be held liable for the provision of information, advice, treatment, or aftercare that fails to meet the accepted standard, and that causes foreseeable harm to someone in sufficiently close proximity.[95] The doctor-

---

that there was no medical evidence to show that the parents' aversion to vaccination was so harmful to the children as to justify state intervention by child protection authorities).

93 See Arthur Caplan, "Liberty Has its Responsibilities: Holding Non-Vaccinators Liable for the Harm They Do" (2013) 9:12 Human Vaccines & Immunotherapeutics 2666 at 2667.

94 For more on medical negligence, see John C Irvine, Philip H Osborne & Mary J Shariff, *Canadian Medical Law: An Introduction for Physicians, Nurses and Other Health Care Professionals*, 4th ed (Toronto: Carswell, 2013) at 85; Micheal A Jones, *Medical Negligence*, 5th ed (Toronto: Sweet & Maxwell, 2018) at 253.

95 The test for finding liability was enunciated in *Donoghue v Stevenson*, [1932]

patient relationship also has fiduciary characteristics wherein the physician owes certain additional duties to the patient.[96] The essence of a fiduciary relationship is that one party (i.e., the physician) pledges to act in the best interest of the other (i.e., the patient). Trust, not self-interest, is at its core. The freedom of the fiduciary is diminished by the nature of the obligations undertaken. These obligations include loyalty, upmost good faith, and avoidance of conflicts of interest.[97] A breach of a physician's fiduciary duty may give rise to a claim against the physician, separate from any claim made in negligence.[98]

In addition to these legal duties, physicians have ethical duties which are articulated in their rules of professional conduct. These codes of conduct, which serve as guides to physicians, are important statements of public policy, and are typically enforced in disciplinary proceedings as part of the profession's self-regulation.[99] They do not, however, necessarily describe the applicable duty or standard of care in negligence (i.e., breaching the rules of professional conduct is not necessarily negligence, and conduct

---

UKHL 100 at 580, and restated in *Anns v Merton London Borough Council*, [1977] UKHL 4 at 751–52. It was adopted in Canada in *Vancouver General Hospital v Fraser*, [1952] 2 SCR 36 at 47, [1952] 3 DLR 785, and refined in *Hopp*, *supra* note 45, and *Reibl*, *supra* note 46. More recently, it has been applied in *Adair Estate v Hamilton Health Sciences Corp*, [2005] OJ No 2180 (QL) at para 128, 32 CCLT (3d); *Fisher v Victoria Hospital*, 2008 ONCA 759 at paras 3–5; *Paxton v Ramji*, 2008 ONCA 697 at paras 29–32; *Anderson v Queen Elizabeth II Health Sciences Centre*, 2012 NSSC 360 at para 41; *Syl Apps Secure Treatment Centre v BD*, 2007 SCC 38 at paras 23–25 (this judgment concerned the treatment of a minor in a secure psychiatric facility).

96 See e.g. *McInerney v MacDonald*, [1992] 2 SCR 138 at para 149, 126 NBR (2d) 271.

97 See *Canadian Aero Service Ltd v O'Malley*, [1974] SCR 592, 40 DLR (3d) 371, reiterated in the doctor-patient context in *Norberg v Wynrib*, [1992] 2 SCR 226, 92 DLR (4th) 449 [*Norberg*].

98 See generally *Stirrett v Cheema*, 2018 ONSC 2595.

99 See generally *Hodgkinson v Simms*, [1994] 3 SCR 377, 117 DLR (4th) 161; *Galambos v Perez*, 2009 CSC 48 [*Galambos*].

may be negligent but not a breach of the rules of professional conduct),[100] although they often overlap significantly.[101]

Since 1868, the Canadian Medical Association (CMA) has published a *Code of Ethics and Professionalism* (*CMA Code*).[102] Although the CMA is an advocacy body with voluntary membership and does not play a regulatory role, the *CMA Code* may be seen as an authoritative statement of Canadian physician ethics, and has frequently been cited by Canadian courts as a yardstick for ethical (though not necessarily legal) medical duties.[103] One of the first duties enumerated in the *CMA Code* is to prioritize the well-being of the patient.[104] Further duties in the *CMA Code* require the physician to:

- Provide "appropriate care" for patients;
- Communicate with patients such that information exchanged is understood;
- Recommend evidence-informed treatment options; and
- Empower patients to make informed decisions.[105]

Perhaps less appreciated is the fact that physicians also owe duties to broader society. Most often, these duties arise in a context of the promotion of public health. For example, the *CMA Code* instructs physicians to:

- Recognize that the social determinants of health and the environment are important factors in the health of individuals and populations;
- Act in matters relating to public and population health; and

---

100 See *Galambos*, *supra* note 99 at para 29. See also *MacDonald Estate v Martin*, [1990] 3 SCR 1235, 77 DLR (4th) 249; Stephen M Grant & Linda R Rothstein, *Lawyers' Professional Liability*, 2nd ed (Toronto: Butterworths, 1998) at 8–10.

101 See e.g. *Grewal v Sandhu*, 2012 BCCA 26.

102 Canadian Medical Association, *CMA Code of Ethics and Professionalism*, Ottawa: CMA, 2018 [*CMA Code*]. See also Nuala P Kenny, "The CMA Code of Ethics: More Room for Reflection" (1996) 155:8 CMAJ 1063.

103 See e.g. *R v Dyment* [1988] 2 SCR 417 at para 29, 55 DLR (4th) 503; *Kelly v Lundgard*, 2001 ABCA 185 at para 221.

104 See *CMA Code*, *supra* note 102 at 2.

105 See *ibid* at 2, arts 5, 6, 11.

- Recognize the responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public.[106]

As discussed earlier, the health, social, and economic benefits of vaccination – both to the individual and to society at large – are well-established. Each province and territory in Canada has a standard immunization schedule for children.[107] Physicians who fail to provide sufficient information regarding the health-supporting and morbidity-reducing potential of vaccinations, and fail to ensure that those recommendations are clearly articulated to the patient (particularly where those vaccines are recommended by official governing bodies) may be in breach of their duties, including those under the *CMA Code*.[108]

B. Physician obligations when accepting new patients

Summary: Physicians face legal and ethical constraints on their ability to choose new patients, the extent of which depends significantly on the geographic location in which the physician practices.

Although physicians have a right to refuse new patients, that right is not absolute: certain legal and ethical considerations shape and constrain that ability.[109] The legal constraints are minimal; as discussed above, Canadian patients do not have an enforceable positive right to health care, suggesting that no physician is legally *required* to accept a patient, so long as the physician does not refuse a patient on grounds prohibited by human rights legislation.[110] Since the physician-patient relationship in this situation has yet

---

106 See *ibid* at 6, arts 38, 39, 41.

107 See Public Health Agency of Canada, *Canada's Provincial and Territorial Routine (and Catch-up) Vaccination Routine Schedule Programs for Infants and Children* (Ottawa: Public Health Agency of Canada, 2018).

108 For a discussion of the standard of care for recommending new (i.e., non-scheduled) vaccines, see "New Vaccines: What Are Your Obligations" (2009), online: *Canadian Medical Protective Association* <www.cmpa-acpm.ca/en/advice-publications/browse-articles/2008/new-vaccines-what-are-your-obligations> [perma.cc/77VB-HU52].

109 See *CMA Code*, *supra* note 102 at 3, art 1.

110 See *Korn v Potter* (1996), 22 BCLR (3d) 163 at para 47, 134 DLR (4th) 437 [*Korn*].

to be established, it is unlikely that there would be sufficient proximity to allow for a tortious (let alone fiduciary) duty to be created.

The *CMA Code* provides only minimal ethical direction on this point. It states that physicians should not discriminate against patients on grounds such as age, gender, or religion. It also affirms the right of physicians to "refuse to accept a patient," but only for "legitimate reasons."[111] No elaboration on what constitutes a legitimate reason is provided.

A review of the provincial and territorial (where available) College of Physicians and Surgeons policies reveals that a physician's ability to prescreen potential patients varies significantly across the country. The Colleges for Newfoundland and Labrador, Nova Scotia, New Brunswick, Ontario, and Yukon suggest that physicians either "should" or "must" use a "first-come, first-served" approach when accepting new patients, although they do allow restricting new patients based on the physician's clinical competence, or the physician's scope of practice.[112] Similarly, the Manitoba College permits physicians to restrict the acceptance of new patients based on criteria such as the physician's clinical competence, medical practice, and the patient's health care needs, but warns that restrictions beyond those criteria are acceptable only in "special or exceptional circumstances."[113]

---

111 *CMA Code*, *supra* note 102 at 3, art 1.

112 See "Standard of Practice: Accepting New Patients" (2017), online (pdf): *College of Physicians and Surgeons of Newfoundland and Labrador* <www.cpsnl.ca/web/files/2017-Mar-11%20-%20%20Accepting%20New%20Patients.pdf> [perma.cc/Z7JH-ELF7]; "Professional Standard and Guidelines Regarding Accepting New Patients" (2016), online (pdf): *College of Physicians and Surgeons of Nova Scotia* <cpsns.ns.ca/wp-content/uploads/2017/10/Accepting-New-Patients.pdf> [perma.cc/W8TW-DZ6T]; "Screening of Potential Patients" (2013), online (pdf): *College of Physicians and Surgeons of New Brunswick* <cpsnb.org/en/medical-act-regulations-and-guidelines/guidelines/454-screening-of-potential-patients> [perma.cc/8FUM-4PZ4]; "Accepting New Patients" (2017), online: *College of Physicians and Surgeons of Ontario* <www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Accepting-New-Patients> [perma.cc/F83D-MLMP]; "Establishing the Physician Patient Relationship", online (pdf): *Yukon Medical Council* <www.yukonmedicalcouncil.ca/pdfs/Establishing_the_Physican_Patient_Relationship.pdf> [perma.cc/X3TP-8TS7].

113 See "Manitoba Standards of Practice Regulation" at 3, online (pdf): *College of Physicians and Surgeons of Manitoba* <www.web2.gov.mb.ca/laws/regs/current/pdf-regs.php?reg=164/2018> [perma.cc/ZZY9-QA8C].

The Colleges in the remaining provinces – Prince Edward Island, Québec, Saskatchewan, Alberta, and British Columbia – appear to take a much more permissive approach to this issue. Prince Edward Island does not appear to have any policy specifically addressing the issue. Québec and Saskatchewan provide only that physicians should not discriminate based on grounds similar to those enumerated in the *CMA Code*.[114] Alberta's policy – despite requiring physicians to use a "first-come, first-served" approach – allows physicians to establish criteria for selecting new patients. However, unlike the other provinces which allow for the establishment of new patient selection criteria, the criteria need not be constrained to the competency or medical scope of practice of the physician.[115] Finally, British Columbia's policy permits physicians to meet with patients to determine mutually whether there is a "good foundation for an effective therapeutic relationship."[116] The physician's ability to decline to take the patient does not appear to be constrained in any way apart from discrimination based on the grounds enumerated in the *CMA Code*.

C. Physician rights to dismiss patients

Summary: Physicians must always have an ethically defensible reason for dismissing a patient. Patients may not be dismissed arbitrarily, for discriminatory reasons, or (in most jurisdictions) for mere failure to follow medical advice.

Upon commencing care for a patient and forming a doctor-patient relationship, physicians have an obligation to render ongoing medical services

---

114 See *Code of Ethics of Physicians*, CQLR c M-9, r 17, s 23 [*Québec Code*]; "Patient-Physician Relationships" (2016) at 1, online (pdf): *College of Physicians and Surgeons of Saskatchewan* <www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Patient-Physician_Relationships.aspx> [perma.cc/26CC-6NSR] [Saskatchewan, "Patient-Physician Relationships"].

115 See College of Physicians and Surgeons of Alberta, "Establishing the Physician-Patient Relationship" (2015), online (pdf): *College of Physicians and Surgeons of Alberta* <www.cpsa.ca/standardspractice/establishing-physician-patient-relationship/> [perma.cc/DT73-AMZU].

116 "Access to Medical Care" (2019) at 3, online (pdf): *College of Physicians and Surgeons of British Columbia* <www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf> [perma.cc/9P64-NCL4].

to that patient. Canadian physicians *are* empowered to dismiss patients, but they must ensure that their actions comply not only with the law relating to fiduciary relationships (which impose obligations of loyalty and non-abandonment) but also with all relevant ethical responsibilities. Courts have not been reluctant to base their findings of a breach of the standard of care on violations of professional codes and responsibilities.[117]

The *CMA Code* requires that physicians continue to treat a patient until one of three criteria is met: (1) services are no longer required or wanted; (2) care is transferred to another physician; or (3) the patient is given reasonable notice of the intent to terminate the relationship.[118] The second and third criteria, while not appearing to require any justification for the dismissal, must be read in conjunction with ethical guidelines and policies adopted by provincial and territorial Colleges, each of which impose some limitations or conditions on physician dismissal of patients. The most permissive approach appears to be that in Prince Edward Island.[119] It acknowledges the *CMA Code* and observes that:

> Occasionally circumstances arise such that the relationship is no longer mutually satisfactory and may not be in the patient's best interest to continue. Either party may terminate a physician-patient relationship, but a physician has certain ethical obligations when he does.[120]

It goes on to say that, although every circumstance must be considered on its own merits, members must:

- Clearly inform the patient of the decision and reasons, preferably with a third-party present;

---

117 See *Egedebo v Windermere District Hospital Association*, [1991] CarswellBC 1771, [1991] BCJ No 2381; *Egedebo v Bueckert*, 78 BCLR (2d) 63, 22 BCAC 314, leave to appeal to SCC refused.

118 *CMA Code*, *supra* note 102, art 2.

119 See "Ending a Physician-Patient Relationship" (2017), online (pdf): *The College of Physicians and Surgeons of Prince Edward Island* <www.cpspei.ca/wp-content/uploads/2018/04/Ending-Physician-Patient-Relationship-May-117.pdf> [perma.cc/79QD-5B3W].

120 *Ibid* at 1.

- Document the process and details of the conversation and keep them on file;
- Send the patient a registered letter confirming the reasons for dismissal and the date beyond which services will not be rendered, and retain a copy on file;
- Advise the patient that other physicians to whom they have been referred will be notified of the change;
- Assist in finding the patient another physician, and transfer records in a timely fashion once consent to do so has been obtained; and
- Provide the patient with a reasonable period of time to find another physician, which period will vary depending on the circumstances, including the reasons for dismissal.[121]

While the Collège des Médecins du Québec also adopts a relatively permissive approach, it permits physicians to dismiss patients only where there exists a "reasonable and just cause to do so."[122] It does not elaborate on what constitutes just cause. As with Québec, the Colleges of Newfoundland and Labrador, Nova Scotia, Manitoba, Saskatchewan, Alberta, and Yukon also require physicians to have reasonable grounds for dismissing a patient. These Colleges also provide prohibited grounds on which physicians cannot dismiss patients. Some such grounds include, "unhealthy" or "poor" lifestyle choices, failing to follow advice (except in cases where the patient is repeatedly non-adherent despite attempts to address the non-adherence), or for discriminatory reasons based on religion, gender, sexual orientation, or political opinion or affiliation.[123] New Brunswick provides that the decision

---

121 See *ibid* at 2. For a detailed discussion of the demands of timely referral in the context of referrals for assisted dying, see *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 [*Christian Medical*].

122 *Québec Code*, *supra* note 114, s 19.

123 See "Ending the Physician-Patient Relationship" (2017), online (pdf): *College of Physicians and Surgeons of Newfoundland and Labrador* <www.cpsnl.ca> [perma.cc/RT69-532E]; "Professional Standard and Guidelines for Ending the Physician-Patient Relationship" (2015) at 2, online (pdf): *College of Physicians and Surgeons of Nova Scotia* <www.cpsns.ns.ca> [perma.cc/DVQ7-TGWZ]; "Standards of Practice of Medicine" (2019) at 29, online (pdf): *The College of Physicians and Surgeons of Manitoba* <www.cpsm.mb.ca> [perma.cc/9E9R-

to terminate will be justified "rarely, if at all" when based on the patient's right to accept or reject any intervention or treatment.[124] British Columbia stipulates that dismissal will be inappropriate if a patient merely respectfully declines to follow the physician's advice.[125] A similar approach was adopted in Ontario.[126]

In addition to these direct constraints on the ability to dismiss patients, other ethical duties may constrain the physician less directly. For example, the *CMA Code* requires physicians to respect the right of competent patients to accept or reject any recommended medical care, and to recognize physicians' own responsibility to promote equitable access to health care resoures.[127] Dismissing patients improperly may, under certain circumstances, constitute a violation of these duties.

Of course, it is important to note that, even if conduct is compliant with the applicable ethical code(s), a physician may still face liability for a violation of relevant legal principles. Illustrative of this is the 1996 case of *Korn v Potter*, wherein the defendant gynecologist refused to provide artificial insemination services to lesbian couples.[128] The College of Physicians and Surgeons of British Columbia dismissed the plaintiffs' complaint, stating

---

YZEC]; Saskatchewan, "Patient-Physician Relationships", *supra* note 114 at 3; "Terminating the Physician-Patient Relationship in Office-Based Settings" (2014), online (pdf): *College of Physicians and Surgeons of Alberta* <www.cpsa.ca>; "Terminating the Physician Patient Relationship in Office-Based Settings" (2014), online (pdf): *Yukon Medical Council* <www.yukonmedicalcouncil.ca> [perma.cc/6DUQ-7775].

124 See "Termination of Care Guideline" (2019), online (pdf): *College of Physicians and Surgeons of New Brunswick* <www.cpsnb.org/en/medical-act-regulations-and-guidelines/guidelines/453-termination-of-care> [perma.cc/8BYQ-AA9S].

125 See "Practice Standard: Ending the Patient-Physician Relationship" (2019) at 3, online (pdf): *College of Physicians and Surgeons of British Columbia* <www.cpsbc.ca/files/pdf/PSG-Ending-the-Patient-Physician-Relationship.pdf> [perma.cc/M2MX-HHRX].

126 See "Ending the Physician-Patient Relationship" (2019), online: *College of Physicians and Surgeons of Ontario* <www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship> [perma.cc/8L5X-EW6A].

127 See *CMA Code*, *supra* note 102, arts 12, 40.

128 See generally *Korn*, *supra* note 110.

that (under the ethical principles of the time) the physician had committed no ethical violation. The patient then made an application to the British Columbia Human Rights Council, which found a human rights violation and awarded damages. On appeal, the Supreme Court of British Columbia confirmed that physicians may be held liable in law despite there being no breach of professional ethical duties.[129] Thus, as demonstrated by *Korn* and as mentioned in certain provincial codes, physicians must also consider other applicable regulation, most pertinently human rights legislation, prior to dismissing a patient.[130]

D. The physician context summarized

Physicians have ethical and legal obligations to provide competent health care to patients, drawing on their specialized skill and professional community, and to do so equitably within the limits of health care system structures and resources. Failure to do so may lead to legal liability or professional discipline. In performing their duties, physicians are required to balance the patient's and community's rights and expectations with their own, including the right to refuse new patients (to different extents, depending on the jurisdiction) as well as the (fiduciary-limited and Code-constrained) right to dismiss patients under certain conditions. However, while those conditions are largely undefined, and may be shaped by different legal instruments depending on the province in question, they are very narrow. The question remains: What are the physician's legal and professional rights and duties in the immunization setting more specifically?

III. The Propriety of Dismissing Vaccine Refusers

Summary: Physicians in all Canadian jurisdictions risk breaching ethical, professional, or legal duties to patients by dismissing vaccine refusers.

---

129 See *ibid* at paras 45–47.

130 The Nova Scotia, Ontario, and British Columbia Codes all make reference to human rights legislation. Other provinces, such as Newfoundland and Labrador, make reference more generally to discriminatory practice. With respect to other instruments, O Reg 856/93, adopted under the *Medicine Act*, 1991, SO 1991, c 30, prohibits discontinuing needed medical services unless the patient requests the discontinuation, alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services.

Physicians who screen potential patients or dismiss vaccine refusers may expose themselves to legal liability and professional discipline.

Once the physician-patient relationship has been created, the starting point for most physicians – in keeping with their duties to promote and protect the health of individuals and the public – will be to strongly recommend immunization. Indeed, they are directed to do so by a wide range of specialist bodies, including the Public Health Agency of Canada, the National Advisory Committee on Immunization, and the Canadian Paediatric Society.[131] If parents refuse to vaccinate themselves or their children – an act which poses a range of risks not only for the child but for those with whom the child comes into contact – physicians may, and increasingly do, feel compelled to dismiss the family from the practice.[132] This compulsion may be grounded in ideological incompatibility, interpersonal conflict a breakdown in the doctor-patient relationship, or the physician's concern for the safety of others in the clinic, among other reasons.[133] However, there are a range of considerations which militate against dismissal for refusal to vaccinate.

First, one must consider the physician's professional guidance. The provincial Colleges require physicians to make reasonable attempts to address non-adherence, favouring a balanced, individualized, and patient-centred approach rather than a blanket policy of dismissal for refusal. The Canadian Medical Protective Association (CMPA) has summarized phys-

---

131 See Public Health Agency of Canada, "Canadian Immunization Guide" (2016), online: *Government of Canada* <www.canada.ca/en/public-health/services/canadian-immunization-guide.html> [perma.cc/A5V5-FNPL]; Dorothy L Moore, "Vaccine Recommendations for Children and Youth for the 2019/2020 Influenza Season" (7 October 2019), online: *Canadian Paediatric Society* <www.cps.ca/en/documents/position/vaccine-recommendations-2019-2020-influenza-season> [perma.cc/ZY4L-UJR7].

132 See Li, *supra* note 12.

133 Scholarship on this matter is minimal, but US research has identified the two most common reasons for dismissal as loss of trust (stemming from the patient's unwillingness to follow professional advice), and the potential risk of infection to those in waiting rooms, see Stan L Block, "The Pediatrician's Dilemma: Refusing the Refusers of Infant Vaccines" (2015) 43:3 JL Med & Ethics 648 at 651; Douglas S Diekema, "Physician Dismissal of Families who Refuse Vaccination: An Ethical Assessment" (2015) 43 JL Med & Ethics 654 at 655; Kenneth Alexander et al, "Should Pediatric Practices Have Policies to Not Care for Children with Vaccine-Hesitant Parents?" (2016) 138:4 Official J American Academy Pediatr 2 at 3.

ician responsibilities in the immunization setting as obtaining appropriate consent to vaccinate, documenting any refusal, and refraining from dismissing refusers, stating that "[p]hysicians should make every effort to continue to care for patients in the existing doctor-patient relationship in accordance with current standards of care."[134]

The College of Physicians and Surgeons of Ontario prohibits dismissal of patients on the sole grounds that they choose not to follow the physician's advice, highlighting the vaccination issue specifically. The College states that "it would be inappropriate for a physician to discontinue the physician-patient relationship solely because the patient did not follow the physician's advice with respect to smoking cessation, drug or alcohol use, *or the patient's decision to refrain from being vaccinated or vaccinating his/her children.*"[135] This explanation of the College's general rule against dismissal for non-compliance with advice may be instructive for interpretation of other provincial Codes.[136]

A number of Colleges – Alberta, Saskatchewan, Manitoba, Nova Scotia, and Newfoundland and Labrador – prohibit dismissal for non-compliance, but include an exception. The Nova Scotia provision states that "[a] physician must not discharge a patient … because the patient refuses to follow medical advice, *unless the patient is repeatedly non-adherent despite reasonable attempts by the physician to address the non-adherence*."[137] On its face, this appears to permit non-compliance dismissal so long as the physician has made repeated, reasonable attempts to convince the patient of the benefits of immunization.[138] However, it remains an open and important question as to what number and what nature of interactions to convince

---

134 "How to Address Vaccine Hesitancy and Refusal by Patients or Their Legal Guardians" (January 2017), online: *Canadian Medical Protective Association* <www.cmpa-acpm.ca/en/advice-publications/browse-articles/2017/how-to-address-vaccine-hesitancy-and-refusal-by-patients-or-their-legal-guardians> [perma.cc/8LFG-GSFH] [CMPA, "Vaccine Hesitancy"].

135 College of Physicians and Surgeons of Ontario, *supra* note 126 [emphasis added].

136 See College of Physicians and Surgeons of New Brunswick, *supra* note 123; College of Physicians and Surgeons of British Columbia, *supra* note 116.

137 College of Physicians and Surgeons of Nova Scotia, *supra* note 123 [emphasis added].

138 See Joan Gilmour et al, "Childhood Immunization: When Physicians and Parents Disagree" (2011) 128:4 Official J American Academy Pediatrics S167 at S169.

the patient to comply is sufficient to satisfy the exception. Further, despite the above exception, most physicians do not routinely dismiss patients who regularly refuse to follow clinical advice with respect to smoking, alcohol consumption, and healthy eating, for example, so dismissing patients for failure to accept vaccines represents an inconsistency, the basis of which is opaque at best and indefensible at worst.

Quite aside from the scope of dismissal rights, it still may not be appropriate for physicians to exercise the "nuclear option" of dismissing patients or families from their practice. First, there remain liability exposures; the doctor-patient relationship is one of unequal power, where physicians have specialist knowledge and expert support structures around them and exercise a gatekeeping function to multiple health services. This power, and concomitant patient reliance on that power, serves to limit the physician's options. Furthermore, the parties act in a context of shortage. There is a shortage of primary care physicians across Canada, with 15.8% of Canadians aged twelve and older (some 4.8 million people) reporting no regular health care provider in 2016.[139] Relying on walk-in clinics may not be deemed a sufficient alternative if a dismissed patient or family resists or complains. As such, physicians hold a considerable amount of power over their patients, and the threat of dismissal could be viewed as unduly coercive. Recall that it is fundamental to health law and ethics that consent to treatment be free and voluntary,[140] so undue pressure (or the perception thereof) to immunize could result in a finding of battery, even in the absence of physical injury.[141] Alternatively, liability could arise under human rights legislation.[142] Human rights laws across Canada prohibit actors, including

---

139 See Statistics Canada, *Primary Health Care Providers*, 2016, Catalogue No 82-625-X (Ottawa: Statistics Canada, 2017) at 3, online (pdf): <www150.statcan.gc.ca/n1/pub/82-625-x/2017001/article/54863-eng.htm> [perma.cc/22U9-HCAM].

140 See *Norberg*, *supra* note 97 at paras 27–34.

141 See *Toews (Guardian ad litem of) v Weisner and South Fraser Health Region*, 2001 BCSC 15 at para 30.

142 Physicians must not only comply with human rights legislation, but also with their professional codes. These codes are meant to be of general application and normative force, establishing broad expectations of physician behaviour and College-articulated tenets of medical professionalism and are subject to *Charter* review: see *Christian Medical*, *supra* note 121.

physicians, from discriminating on the basis of religion.[143] Thus, patients whose sincerely-held religious beliefs preclude them from accepting a vaccination may seek human rights redress against a physician who has dismissed them for such a refusal.

Second, aside from liability, the act of dismissal could set up an unethical (equity-breaching) access-to-care barrier, especially in communities with a deficit of family doctors. This can be most damaging to the child, who could be left without a family physician or sufficient health care support. It has been argued that dismissal cannot be an ethical response to vaccine hesitancy or refusal because it cannot under any circumstances be said to be in the child's best interests, nor does it benefit the public's health.[144] Rather, it punishes the child for their parents' and practitioner's respective inflexibility, while also eliminating any further opportunity for the physician to work with the family in respect of immunization or any other matter of health. This view is reiterated in a Position Statement from the Canadian Paediatric Society (CPS), which recommends against the dismissal of *children* whose parents refuse to immunize, stating that threats of dismissal are unlikely to prompt the parents to agree to immunization and that continuing the relationship provides an ongoing opportunity to discuss vaccination.[145] Again, keeping refusers in ones' practice, even if potentially uncomfortable and demanding of special precautions (such as increased infection control measures), provides ongoing opportunities for further discussion, and eventual immunization; research has shown that physician reassurance is a key factor in encouraging vaccine refuser parents to ultimately accept immunization for their children.[146]

---

143 See *Korn*, *supra* note 110 at para 47; *Canadian Human Rights Act*, RSC 1985, c H-6, s 3(1); *Charter*, *supra* note 27, s 10.

144 See Halperin, *supra* note 14 at 845.

145 See Noni MacDonald, Shalini Desai & Betty Gerstein, "Practice Point: Working With Vaccine-Hesitant Parents: An Update" (14 September 2018), online: *Canadian Paediatric Society* <www.cps.ca/en/documents/position/working-with-vaccine-hesitant-parents> [perma.cc/W4QA-3EPB].

146 See *ibid* at 2; Marissa Wheeler & Alison M Buttenheim, "Parental Vaccine Concerns, Information Source, and Choice of Alternative Immunization Schedules" (2013) 9:8 Human Vaccines & Immunotherapeutics 1782 at 1788; Sara C Gordon & Noni E MacDonald, "Dealing with Measles in Dental Practice: A Forgotten Foe Makes a Comeback" (2015) 146:7 JADA 558 at 559–60; Cristina Giambi et al, "Parental Vaccine Hesitancy in Italy – Results From a National Survey" (2018) 36:6 Vaccine 779 at 785–87.

In addition to the above, dismissal may be viewed as a breach of several ethical principles core to the physician's role, such as:

- Patient Autonomy: It is axiomatic that patients have the right to refuse treatments, including vaccinations, even if to do so is foolhardy and dangerous. Despite its limited application, this principle serves to remind the physician that patients are within their rights to refuse. For patients who are incapable (such as infants), the principle of patient autonomy extends to the patient's substitute decision maker – within, of course, certain constraints, some of which were discussed earlier.

- Beneficence and Non-Maleficence: Physicians must act in the interest of their patients, doing good and minimizing harm. Dismissal undermines the duty to care for every patient no matter what their beliefs, values, and attitudes may be, and could result in all manner of health-related harms.[147]

- Solidarity: Physicians must stand with their patients, bearing costs for them and advocating for them.[148] When dismissing refusers, they undermine the solidarity that they are expected to show with their most vulnerable of patients: children. Indeed, it is this solidarity with the child patient that rightly serves to counterbalance the parents' autonomy, offering the physician further tools and justifications.[149]

- Justice: Dismissal infringes the principle of distributive justice both directly by impeding equitable access to health care, and indirectly by shifting the clinical burden of treating that family to those physicians who choose not to dismiss for refusal.[150]

Ultimately, dismissal will only be ethical and legal under very narrow circumstances, and only in certain jurisdictions, and it will rarely be the proper or best course of action. Many factors correctly serve to limit physician rights to dismiss patients who persistently refuse to immunize. Even

---

147 See Diekema, *supra* note 135 at 656, 658.

148 See Nancy E Kass, "An Ethics Framework for Public Health" (2001) 91:11 American J Public Health 1776 at 1781–82; Ross EG Upshur, "Principles for the Justification of Public Health Intervention" (2002) 93:2 Can J Public Health 101 at 102–03.

149 For further discussion, see *infra* Part IV.

150 See Halperin, *supra* note 14.

if physicians are adamant that the relationship has irreparably broken down due to persistent refusals to immunize, they must nonetheless exercise utmost caution and restraint in relation to dismissal because many of the College policies take a very restrictive view. The New Brunswick, Ontario, and British Columbia Colleges make it clear that dismissals will rarely be ethically justifiable. The other provinces, save for Prince Edward Island and Québec, will only permit dismissal after repeated reasonable attempts have failed to obtain compliance. Even then, physicians risk violating other ethical, professional, or legal rules (e.g., *CMA Code* rules permitting patient refusal of treatments, human rights equality standards, or *Charter* guarantees of patient rights). Physicians should therefore consider how best to manage vaccine refusers within their practice.

All of this raises the question of whether physicians might (or should) take greater care in the patient pre-screening (or acceptance) process to determine the patient's vaccine perspective, before taking them on. This is a complicated matter that is outside the scope of this paper, but it is nonetheless worthy of comment. As indicated above, the geographic location in which a physician practises has a significant impact on the physician's ability to pre-screen potential vaccine refusers. Those jurisdictions that restrict selection criteria to the physician's scope of practice or medical competency appear therefore to severely constrain the physician's capacity to refuse a patient for vaccine hesitancy or refusal. In these jurisdictions, refusing a vaccine hesitant patient would constitute a direct breach of the College's requirements, exposing the physician to professional discipline by their regulatory body. In those jurisdictions with broader pre-screening powers, the option may exist, but such pre-screening of vaccine-refusers obviously opens the physician up to charges of discrimination, and then professional and legal sanction. Our own experience suggests that, in practice, such inquiries do not form part of the pre-screening or patient application process, and correctly so.

IV. Managing Vaccine Refusers in the Clinic

Summary: There are numerous strategies clinicians may employ to maintain a positive doctor-patient relationship with vaccine refusers. Continuation of that relationship is desirable for both public and individual reasons and is likely the only platform from which a vaccine-refusing patient or parent might be convinced, through sound evidence, to ultimately accept vaccination.

Most vaccine refusers are not particularly entrenched in their position.[151] However, as noted, the refusing parent's social networks – both personal and online – may reinforce their hesitancy by being explicitly vaccine-negative.[152] Indeed, studies show that anti-vaccination social media can be very influential. Just five to ten minutes on a vaccine-critical website can change one's perception of vaccine safety and effectiveness, and influence vaccination intentions.[153] Physicians must cautiously counteract those influences. They must provide good information in comprehensible formats to enable patients to make an informed choice about immunization. Both content and presentation should be non-adversarial and tailored to fit the parent's or patient's needs and capabilities.[154] To preserve the doctor-patient relationship, and potentially lead the patient to a vaccine-accepting stance, physicians might adopt the following "Seven 'A's" strategy:[155]

- Avoid Confrontation: While vaccine refusers can be frustrating for physicians to counsel, having a debate about immunization is not particularly helpful, and may further entrench vaccine-negative views. Overly strong or strident messaging can often sound like an attack on beliefs, making it unlikely that the refuser will hear the message.[156] A 2010 survey of Ontario parents with children under

---

151 See Noni E MacDonald & Jane C Finlay, "Working with Vaccine-Hesitant Parents" (2013) 18:5 Paediatr & Child Health 265 at 267.

152 See Chris T Bauch & Alison P Galvani, "Social Factors in Epidemiology" (2013) 342:6154 Science 47 at 48–49; Katie Attwell & Melanie Freeman, "Immunise: An Evaluation of a Values-Based Campaign to Change Attitudes and Beliefs" (2015) 33:46 Vaccine 6235 at 6237, 6239.

153 See generally Cornelia Betsch et al, "The Influence of Vaccine-Critical Websites on Perceiving Vaccination Risks" (2010) 15:3 J Health Psychol 446.

154 See *Arndt v Smith*, [1997] 2 SCR 539 at para 15, 148 DLR (4th) 48; and more recently *Revell v Chow*, 2010 ONCA 353 at para 55; *Prevost v Ali*, 2011 SKCA 050 at para 38; *Lemay v Peters*, 2014 NBCA 59 at para 35.

155 These strategies have been compiled from recommendations made in Eve Dube et al, "Vaccine Acceptance, Hesitancy and Refusal in Canada: Challenges and Potential Approaches" (2016) 42:12 Can Communicable Disease Rep 246; Susan Goldstein et al, "Health Communication and Vaccine Hesitancy" (2015) 33:34 Vaccine 4212 at 4213; Shixin Shen & Vinita Dubey, "Addressing Vaccine Hesitancy: Clinical Guidance for Primary Care Physicians Working with Parents" (2019) 65:3 Can Fam Physician 175 at 177, as well as other sources cited below.

156 See Noni MacDonald, Jennifer Smith & Mary Appleton, "Risk Perception,

age sixteen presenting for naturopathic care reported that a majority (50.5%) felt pressure from their allopathic physician to vaccinate.[157] Of those who discussed vaccination with their physician, 25.9% were less comfortable continuing care as a result, and 5% were advised by their physician that their children would be refused care if they decided against vaccination. Parents reported excessive pressure to vaccinate, and felt that discussions were not balanced, injecting a sense of conflict into the relationship. Thus, first and foremost, respectful discourse is critical to good doctor-patient relationships. Even highly resistant populations can change their views, but that requires targeted messages that build on community values delivered in non-confrontational ways.[158] Physicians should therefore minimize adversarial and positional stances and eschew overtly pressurized tactics. They should avoid repeating vaccination myths lest repetition reinforce those myths among patients.[159] More collegial and motivational interactions can be woven into a routine visit with only a small increase in time.[160]

- Accept: It is important to accept and embrace the parent or patient refuser as an autonomous person deserving dignity, and make them know that, regardless of their decision, their opinions are valued. Physicians should not reject a refuser's values outright. More importantly, physicians should remember that it is the *child* who is the patient of concern, and that there is no basis for rejecting that patient.

- Affirm: Physicians should acknowledge that the parents have good intentions toward the child and that this is a source of common ground. Such an acknowledgement can be powerful. It affirms that both the parent and the physician want the child to be safe, healthy,

---

Risk Management and Safety Assessment: What Can Governments Do to Increase Public Confidence in Their Vaccine System?" (2012) 40:5 Biologicals 384 at 385; Holly O Witteman, "Addressing Vaccine Hesitancy with Values" (2015) 136:2 Pediatr 215 at 216.

157 See Jason W Busse, Rishma Walji & Kumanan Wilson, "Parents' Experiences Discussing Pediatric Vaccination with Healthcare Providers: A Survey of Canadian Naturopathic Patients" (2011) 6:8 PLOS One e22737 at 3.

158 See Witteman, *supra* note 156.

159 See Ian Skurnik et al, "How Warnings About False Claims Become Recommendations" (2005) 31:4 J Consum Res 713 at 719.

160 See Julie Leask et al, "Communicating with Parents About Vaccination: A Framework for Health Professionals" (2012) 12:154 BMC Pediatr 154 at 158.

and happy. This builds trust and allows for further (and more persuasive) conversations to be had in the future.[161]

- Actively Listen: The physician should never assume or guess why the patient or parent is refusing immunization.[162] Instead, he or she should ask parents about their worries regarding vaccination, and about their understanding of disease risks and vaccine benefits. Physicians should attempt to understand the values which informed the decision to refuse immunization. Listening to the parent's or patient's responses is key, and correcting specific misconceptions is critical.[163]

- Advise: Physicians are typically trusted advisors. They should therefore remind parents that not making a decision about immunization is itself a decision (i.e., help correct the "omission bias"). Physicians must ensure that they have advised patients not only of the personal benefits of immunization, but also of the public health benefits, and the potential consequences of non-immunization: that their healthy unvaccinated child may spread a vaccine-preventable disease to high-risk individuals.[164] Presenting information and outcomes in terms of gains and losses can be powerful,[165] and can better direct patients to trusted and reputable sources of further information.

- Advocate: Physicians should always remain an advocate for the *patient*, who is the child. They should therefore ensure that discussion does not focus on the parent's (or physician's) subjective beliefs or fears, but rather on objective evidence from reliable sources of the benefits of vaccination for the child. While physicians should not hesitate to advocate strongly, it is of course important to remain empathetic and sensitive to the parents' concerns.

---

161 See Dan M Kahan, Hank Jenkins-Smith & Donald Braman, "Cultural Cognition of Scientific Consensus" (2011) 14 J Risk Res 147 at 169.

162 See Daniel A Salmon et al, "Factors Associated with Refusal of Childhood Vaccines Among Parents of School-Aged Children: A Case-Control Study" (2005) 159:5 Arch of Pediatr & Adolesc Med 470 at 471; C Mary Healey & Larry K Pickering, "How to Communicate with Vaccine-Hesitant Parents" (2011) 127 (Supp 1) Pediatr S127 at S129.

163 See MacDonald & Finlay, *supra* note 151 at 265.

164 See *ibid* at 266.

165 See generally Mary A Gerend & Janet E Shepherd, "Using Message Framing to Promote Acceptance of the Human Papillomavirus Vaccine" (2007) 26:6 Health Psychol 745.

- Annotate: Physicians should document in the patient's chart the refusal and the reasons for refusal (or hesitancy), noting that the benefits, risks and responsibilities have all been reviewed.[166]

If the parent or patient still refuses vaccination, physicians should continue to pursue open dialogue with the parent or patient. An effective approach might be as follows:

1. Open-ended questioning (e.g., What do you think about vaccines?)
2. Affirmation (e.g., I understand…)
3. Reflection (e.g., You are concerned by/that…)
4. Correction (e.g., The evidence is that…)
5. Benefit/risk articulation (e.g., The consequences are…)
6. Summarization (e.g., Let me summarize…)

This approach has proven to be extremely effective at bringing parties together in the vaccine hesitancy setting.[167]

Second, if this approach has been pursued in the paediatric context, and the patient's parent persists in his or her refusal, then physicians should consider whether the use of child protection legislation is appropriate. If the physician considers the child to be at risk, the physician may consider seeking further advice from the CMPA, local child welfare authorities (on a "no-name of patient" basis), or a local child abuse or neglect medical clinic. If appropriate, an application can then be made under the provincial child protection scheme to have the child vaccinated contrary to parental wishes. Indeed, physicians have a special legal duty to report suspicions of child abuse or neglect to authorities. While it may be difficult to characterize non-immunization as abuse or neglect, section 22(2)(e) of the Nova Sco-

---

166 In general, this step is highly recommended: see CMPA, "Vaccine Hesitancy", *supra* note 134 at 2.

167 See generally Arnaud Gagneur, Virginie Gosselin & Ève Dubé, "Motivational Interviewing: A Promising Tool to Address Vaccine Hesitancy" (2018) 36:44 Vaccine 6553; Jenna Reno et al, "Evaluation of the Implementation of a Multicomponent Intervention to Improve Health Care Provider Communication About Human Papillomavirus Vaccination" (2018) 18:8 Academic Pediatrics 882.

tia *Children and Family Services Act*[168], for example, requires physicians to notify child protection authorities when a child requires, among other things, medical treatment to prevent physical harm or suffering, and the child's parent or guardian does not provide, or refuses the treatment. Similar legislation exists in all other provinces and territories.[169] The availability of this course is recognized by the CMPA, which advises as follows: "Where a patient (or a patient's legal guardian) has refused immunization, but the vaccine is medically appropriate and necessary to preserve the life or health of the child, it may be necessary for physicians to contact child protection agencies."[170]

Physicians are very unlikely to be sanctioned, either legally or professionally, for a good faith referral to child welfare agencies.[171] However, such referrals can have complex consequences and are likely to end the doctor-patient relationship. They should be made only when the life or health of the child is directly threatened, for example in cases of measles or diphtheria, or during meningococcal outbreaks. In such situations, the physician acts in solidarity with the minor. The child has someone considering his or her best interests, and the physician fulfills his or her advocacy responsibilities.

In situations where the patient is not a child, or an application under child protection legislation would be inappropriate (or was unsuccessful), and all efforts to encourage vaccination have failed, physicians ultimately have little legal recourse. While this may be difficult or frustrating for the physician, the seminal medical-legal and medical-ethical principle of self-autonomy, as discussed above, must take precedence over the physician's discomfort. In addition to being the correct legal and ethical route, the continuation of the physician-vaccine refuser relationship is preferable at all times to its termination, since it affords the opportunity for trust to be built in the future.

---

168 *Supra* note 60, s 22(2)(e).

169 See Canadian Medical Protective Association, "Protecting Children: Reporting Child Abuse" (March 2012), online: <www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/protecting-children-reporting-child-abuse> [perma.cc/DX7L-M9EW] [CMPA, "Protecting Children"].

170 CMPA, "Vaccine Hesitancy", *supra* note 134.

171 See CMPA, "Protecting Children", *supra* note 169.

Conclusion

Vaccine hesitancy has increased in Canada, and patient dismissal for vaccine refusal has also become more common. Our analysis has demonstrated that the right to dismiss patients is incredibly narrow, and recourse should not readily be made to it. Indeed, the *CMA Code* acknowledges that physicians may simply have to deal with tension between different ethical principles, between ethical and legal or regulatory demands, and between their own ethical convictions and the needs of others. The *CMA Code* instructs physicians to prioritize the well-being of the patient, to recognize and disclose conflicts of interest, and to resolve them in the best interests of the patient.[172] Physicians, and those who advise them, should therefore be reminded that there is a complex array of ethical, legal, and social considerations which must be weighed on a case-by-case basis before dismissal can be justifiable, and dismissal as a blanket policy should be rejected outright. Instead, the individual circumstance of each vaccine-refusing patient must be carefully assessed with particular attention paid to the best interests of the child.

The most powerful tool for combating vaccine hesitancy and refusal is a good doctor-patient relationship, the maintenance of which is at the heart of the physician's legal, ethical, and professional responsibilities. A strong and continuing relationship preserves the possibility of future engagements, including ones that alter the stance of the vaccine refuser. Further, learning to disagree in a cordial and honest way with minimal conflict is important for both physicians and patients, as is the gradual accumulation of the trust that may lead to informed decision-making, and ultimately to vaccine acceptance. Given the central role that immunization programs play in meeting state health objectives and obligations, provincial or federal immunization regulations should be adopted which better highlight and clarify the responsibilities and rights of all parties implicated in the immunization setting. Additionally, policymakers such as national and provincial professional Colleges should offer more specific instruction (similar to the clarifications proffered by the Canadian Paediatric Society and the Ontario College) as to how physicians can best meet their public health responsibilities, how to deal with parents who are acting in ways they consider to be contrary to the child patient's interests, and what constitutes reasonable attempts to address non-compliance.

---

172 *CMA Code*, *supra* note 102, arts 23–24.