Montreal 2017 Montréal

Editor-in-Chief
Rédacteur en chef
BENNY CHAN

English Executive Editor
Rédactrice exécutive pour l’anglais
AGATHA WONG

Executive Managing Editor
Rédactrice administrative exécutive
KENDRA LEVASSEUR

Senior Editors / Rédactrices séniors
CLAIRe BentLeY
STEFAnIE CArDArellI
TARa MagILL
CAMILLE MArCEAU
ELSPETH MCMurrAY

Editors / Rédacteurs
LAURa ALFORD
XiN CI
GREGORY COrOSkY
XAVIer FOCcroULLe-MEnArD
LAURENCE gARON
ALEKSANDER GODLEWSKI
PHIL LORD
TIMOTHY NIESM
ERIC SARAGOSA
ZACHARY SHIFMAN
ALEK WARSBECK

Senior Strategic Planning & Solicitations Editor
Rédacteur séniors pour la planification stratégique et la sollicitation
JENS ZENTIL

Strategic Planning & Solicitations Editors
Rédacteurs pour la planification stratégique et la sollicitation
LINDA AG ABy
CLAIRe BentLeY
LAUREN HANON
DAVID MCLeOd
SAMANTHA SAMUELs

McGill Journal of Law and Health ~ Revue de droit et santé de McGill

ISSN: 1920 – 4825 (Print Edition), 1920 – 4833 (Online Edition)
EDITOR’S NOTE ................................................................. Benny Chan v

ARTICLES

RESEARCHER-PARTICIPANT PRIVILEGE, CONFIDENTIALITY, AND THE JAILHOUSE BLUES .............................................. Karen Drake & Richard Maundrell 1

LET THY CONSCIENCE BE THY GUIDE (BUT NOT MY GUIDE): PHYSICIANS AND THE DUTY TO REFER ........................................ Daphne Gilbert 47

MEDICARE AND THE NON-INSURED HEALTH BENEFITS AND INTERIM FEDERAL HEALTH PROGRAMS: A PROCEDURAL JUSTICE ANALYSIS ................. Michael Da Silva 101
Entering its 10th year of publication, the McGill Journal of Law and Health has taken its place among Canada’s leading law journals. The journal was founded in 2005 under the name of the McGill Health Law Publication and published its inaugural issue in 2007. It has since grown by leaps and bounds, both in its membership and in the complexity of its operations. What has remained constant is the MJLH’s commitment to publishing work of the highest calibre that addresses some of the most complex and cutting-edge issues facing the legal community today. Through the work of its dedicated editors and peer reviewers, the MJLH has established itself as a platform for academic work destined to make an impact. The range of topics addressed by authors in the journal is as expansive as the field of health law itself; recent issues contain articles on biotechnology, pharmaceutical regulation, assisted reproduction, and assisted dying. With the articles in this 10th anniversary issue, we reaffirm our commitment to promoting academic excellence in this vitally important area of law.

In the first article of Issue 10:2, Professors Karen Drake and Richard Maundrell examine the limits of a researcher’s duty of confidentiality to his or her research subjects. Social scientists working in fields such as criminology and public health often conduct their research under the spectre that a court will order the disclosure of their participants’ data (e.g., to assist in a criminal investigation or to assess civil liability). Given this possibility of judicially compelled disclosure, can researchers make an unconditional promise of confidentiality to research participants? Ted Palys and John Lowman, criminologists at Simon Fraser University, have long argued in the affirmative. A researcher can make such a promise in good faith if he or she designs research protocols in such a way that will guarantee a successful invocation of researcher-participant privilege and if the researcher avoids the use of qualifying phrases in confidentiality agreements, such as “except as required by law.” In their response to Palys and Lowman’s position, Drake and Maundrell argue that these measures are neither sufficient nor necessary to shield a researcher from compelled disclosure. With respect to sufficiency, researchers can never guarantee that a court will find the value of protecting confidentiality in a given instance to outweigh the public interest in disclosure. The result is that researchers can never completely immunize their data from being the target of a disclosure order. And not only is an unconditional promise of confidentiality insufficient to support a claim of researcher-participant privilege, the case law suggests that such a promise may not even be necessary. Drake and Maundrell further argue that an unconditional promise would be inappropriate as researchers arguably have an ethical duty to
warn research participants of the material risk that a court will compel disclosure of research data. Through their careful engagement with Pals and Lowman’s publications, the authors mount a formidable challenge to the idea that researchers can – on legal and ethical grounds – make an unlimited promise of confidentiality to their human research subjects.

The second article, authored by Professor Daphne Gilbert, addresses the limits of another legal concept – that of a physician’s right of conscientious objection when it comes to providing abortion services. The immediate target of Gilbert’s argument is a Canadian Charter of Rights and Freedoms challenge brought by a number of physicians’ groups and individual physicians against a policy recently enacted by the College of Physicians and Surgeons of Ontario. This new policy requires physicians who refuse to perform abortions on religious/conscientious grounds to offer effective referrals when faced with requests for these services. Gilbert argues that this Charter challenge is ill-founded. Moreover, she puts forward the proposition that a physician’s refusal to provide effective referrals for abortion should trigger Charter scrutiny. In support of this point, Gilbert makes the claim that the Charter is directly applicable to the work of physicians by virtue of the monopoly that physicians enjoy over the provision of a government-funded public service and as a consequence of self-regulation. On the question of how to balance a physician’s Charter right to act on the basis of his or her conscience with a woman’s Charter right to obtain an abortion, Gilbert is unequivocal that the latter should prevail. Indeed, she questions whether physicians who harbour conscientious objections to abortion should be allowed to practice front line medicine at all. Some of Gilbert’s conclusions may come across as controversial. Nonetheless, her argument does provide one clear position on how courts should resolve seemingly intractable rights conflicts.

In the issue’s third and final article, Michael Da Silva subjects aspects of the Canadian health care system to a procedural fairness analysis. In particular, Da Silva examines whether resource allocation decisions are made in a way that complies with Norman Daniels and James Sabin’s Accountability for Reasonableness (AFR) framework. Under AFR, a fair method of resource allocation ought to be transparent, be based on reasons that are actually or hypothetically accepted by the public, and include procedures for appealing/reviewing the initial decisions. On the first criterion, Da Silva’s analysis suggests there is a lack of transparency in governments’ provision of reasons for their health care decisions. At the provincial level, the committees charged with deciding health care coverage in a given province are generally not required to provide reasons for their decisions. Nor are they normally required to make their reasons public. At the federal level, Da Silva considers the government’s reasons for decisions relating to the provision of services under the Interim Federal Health Program (IFHP). This program provides health care funding to refugees and others who seek the protection of Canada, but do not qualify for Medicare. Not only does the federal government make IFHP decisions without adequate public consultation, it is notoriously opaque when it comes to its reasons for covering, and refusing to cover, health care goods under the program. With regard to the second criterion, Da Silva argues that Canadians lack sufficient information
to either actually or hypothetically accept the reasons for decisions made by public bodies in the health care context. And while challenge and review mechanisms are nominally available – fulfilling the appeal/review criterion of AFR – such mechanisms often fail to result in substantive changes. Da Silva’s discussion is a sobering reminder that aspects of the Canadian health care system can be improved in matters of procedural fairness.

***

Moving a manuscript from the initial review stage to publication is a Herculean task requiring the efforts of a whole team of students. It has been a privilege to work alongside executive editors Joshua Crowe and Agatha Wong of Volume 10. I also owe a debt of gratitude to Volume 11 executives Kendra Levasseur, Camille Marceau, and Zachary Shefman for putting the finishing touches on the volume. Each of them displayed a level of commitment that exceeded my wildest expectations. The journal would be lost if we did not have leaders of their calibre. Above all, the MJLH owes its success to the front line editors who have spent countless hours reviewing, source checking, and editing our articles. It is to them – MJLH editors past and present – that I would like to dedicate this issue.

À votre santé!

Benny Chan
Research participants can be expected to share legally sensitive information only when they are confident that those with whom they are sharing it can be trusted to maintain its security and confidentiality. However, researchers can never be certain that their participants’ data will not become the target of a judicial order for disclosure in the form of a subpoena or search warrant. Judicially compelled disclosure places the researcher in a conflict of duties between honouring the ethical responsibility to protect participant confidentiality on the one hand, and the legal duty to comply with the law on the other. Criminologists Ted Palys and John Lowman argue that, where such a conflict arises, the researcher retains the right to resist disclosure as a matter of principle; on the grounds that ethical principle transcends law, researchers may adopt an “ethics-first” approach in which a disposition to noncompliance with compelled disclosure would guide research practice from the earliest stages of research design. The alternative to an ethics-first approach

Karen Drake* & Richard Maundrell**


would be the “law-of-the-land” approach, in which participants would be informed that confidentiality would be maintained only to the extent permitted by law. Under a law-of-the-land approach, the researcher would comply with a judicial order for disclosure once all legal means of resisting it have been exhausted. There are three arguments in Palys and Lowman’s case for ethics-first: (1) that the best way to protect confidentiality is to “Wigmorize” it in anticipation of a judicial test of privilege; (2) that to offer a qualified promise of confidentiality would be to undermine any claim to privilege according to Wigmore criteria; and (3) that to warn participants about the possibility of court-ordered disclosure is unnecessary, because such an eventuality does not qualify as a reasonably foreseeable risk. All three arguments are subject to criticism on legal grounds, while the suggestion that civil disobedience can be an appropriate way of responding to compelled disclosure is criticized on philosophical grounds.

INTRODUCTION

I. “LAW-OF-THE-LAND” VERSUS “ETHICS-FIRST”: A CRITICAL ANALYSIS

A. The first strand: “Wigmorize” the research data

B. The second strand: Does the first Wigmore criterion require an unlimited promise of confidentiality?

C. The third strand: Is court-ordered disclosure reasonably foreseeable?

1. Which risks are reasonably foreseeable?

2. Practical limitations of a civil disobedience ethic

3. Civil disobedience: Some philosophical considerations

II. IMPLICATIONS FOR RESEARCHERS AND RESEARCH ETHICS BOARDS

CONCLUSION


**INTRODUCTION**

Human participant research is an essential tool for the pursuit of knowledge both as a good in itself and as one of the principal instruments of progress in medicine, social policy, and justice. But the collection of personal data can, sometimes in ways impossible to anticipate, place information in the hands of researchers that will later be targeted for disclosure by a subpoena or search warrant. Research participants can be expected to share certain kinds of information about themselves only when they have strong reasons to believe that it will remain confidential. Moreover, an important part of the informed consent process by which people are enrolled as research participants is an explanation of the measures the researcher is prepared to take to maintain confidentiality. A judicial order for the disclosure of research data will place the researcher in a conflict of duties between honouring the trust upon which the researcher-participant relationship is based, and the legal duty to comply with the law. A researcher might reduce the potential for such a conflict by informing participants about the risk of compelled disclosure as part of the consent process, but offering participants a qualified assurance of confidentiality might compromise the quality of information a researcher can expect to obtain.¹

The *Tri-Council Policy Statement (TCPS2 2014)*, which sets out federal guidelines for the conduct of human participant research in Canada, advises researchers that the protection of participant confidentiality is an ethical duty “central to respect for participants and the integrity of the research project.”² It also acknowledges that tensions can arise between “the requirements of the law and the guidance of the ethical principles” set out in the

---

¹ This dilemma can also be characterized as the choice between making an unlimited promise of confidentiality, which will be proven to have been misleading should research data be subjected to court-ordered disclosure, and warning participants that their data may be subject to court-ordered disclosure, which can discourage participation (see Marvin E Wolfgang, “Confidentiality in Criminological Research and Other Ethical Issues” (1981) 72:1 J Crim L & Criminology 345 at 349–50).

Tensions of this kind are most likely to arise where research data is targeted for disclosure by judicial order in the form of a subpoena or search warrant. Such a situation raises the issue of whether research data is protected by researcher-participant privilege.

The Supreme Court of Canada adopted the Wigmore test as the appropriate judicial mechanism to assess claims of privilege in *R v Gruenke* in 1991. The common law recognizes that communications arising from certain relationships, such as the solicitor-client relationship, are presumptively privileged and hence inadmissible as evidence. These communications are said to be protected by a “class” privilege: one need only demonstrate that the particular relationship at issue falls within a recognized class in order to receive the benefit of the presumption of inadmissibility. In *Gruenke*, the Supreme Court of Canada established definitively that all other communications are presumptively admissible, but that this presumption will be rebutted if the communications at issue satisfy the following four criteria of the Wigmore test:

1. The communications must originate in a confidence that they will not be disclosed.
2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
3. The relation must be one which in the opinion of the community ought to be sedulously fostered.

---

3 *Ibid* at 10.

4 A related issue concerns the circumstances under which a researcher is legally or ethically obligated to disclose identifiable research data collected under a promise of confidentiality, not because of a judicial order for disclosure, but for the sake of preventing harm. This issue is beyond the scope of this paper. For a thorough consideration of this topic, see Derek J Jones & Interagency Advisory Panel on Research Ethics, “Interface of Law & Ethics in Canadian Research Ethics Standards: An Advisory Opinion on Confidentiality, Its Limits, & Duties to Others” (2007) 1:1 McGill Health L Publication (McGill JL & Health) 101.

5 [1991] 3 SCR 263, 67 CCC (3d) 289 [*Gruenke* cited to SCR].

6 *Ibid* at 286.

7 *Ibid* (establishing that this presumption can then be rebutted by establishing an exception to the general rule).
(4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.  

Communications that are presumptively admissible, but which satisfy all four of the Wigmore criteria, are protected by “case-by-case” privilege, as opposed to class privilege.

At the time of writing, researchers have challenged orders for disclosure of research data by asserting researcher-participant privilege on only two occasions in Canadian legal history. In 1994 Russel Ogden, then a graduate student in the School of Criminology at Simon Fraser University, was subpoenaed by a coroner regarding his research on assisted suicide in the HIV/AIDS community in Vancouver. The coroner wished to know the identity of a person who was thought to have assisted in the suicide attempt of an

---

8 Gruenke, supra note 5 at 284 [emphasis omitted], citing John Henry Wigmore, *Evidence in Trials at Common Law*, vol 8, ed by Colin McNaughton (Boston: Little, Brown and Company, 1961) at §2285. The Wigmore test was first introduced into Canadian jurisprudence in *Slavutych v Baker* [1976] 1 SCR 254, 55 DLR (3d) 224 [*Slavutych* cited to SCR], where the Supreme Court of Canada held in *obiter* that the communication at issue was privileged, because it met all four Wigmore criteria (Sidney N Lederman, Alan W Bryant & Michelle K Fuerst, *The Law of Evidence in Canada*, 4th ed (Markham, Ont: LexisNexis Canada, 2014) at paras 14.16–14.19). It was not until its decision in *Gruenke*, though, that the Court determined conclusively that the Wigmore criteria are to be used to assess case-by-case privilege (*ibid* at para 14.22).

9 *Gruenke*, supra note 5 at 286.

10 Ted Palys & John Lowman, *Protecting Research Confidentiality: What Happens When Law and Ethics Collide* (Toronto: James Lorimer and Company, 2014) at 28, 40 [Palys & Lowman, *Protecting Research Confidentiality*]. In the interest of full disclosure, it should be noted that Ted Palys and John Lowman were professors in the Department of Criminology at Simon Fraser University when Russell Ogden entered the MA program in Criminology at that institution in September, 1991. However, neither Palys nor Lowman served as members of his thesis committee. Ogden’s thesis supervisor when he entered the program was Dr. Robert Gordon who was standing in for Dr. Brian Burtch until he returned from a sabbatical leave in July, 1992. Dr. Burtch was replaced as Ogden’s thesis supervisor by Dr. Verdun-Jones on December 8, 1992. Ogden successfully defended his thesis on February 8, 1994. Ogden received a subpoena to testify before a coroner’s inquest on May 25, 1994 (*Ogden v Simon Fraser University*, [1998] BCJ No 2288 (QL) at paras 2–3, 7, 1998 Carswell-BC 3260 [*Ogden*]).
AIDS victim who had botched an attempt to end her life with an overdose of Seconal. The incident came to the attention of the coroner through an article in the *Vancouver Province*11 published in May 1991, several months before Ogden entered the Master of Arts program at Simon Fraser University.12 When asked about his knowledge of the case at the coroner’s inquest, Ogden refused to answer, arguing that any of his communications with his research participants was privileged.13 The coroner agreed with Ogden and released him from further questioning.14

On June 4, 2012, Luka Magnotta, a Montreal sex worker, was arrested for the murder and dismemberment of Montreal university student Lin Jun. On April 12, 2013, Magnotta was indicted on charges of first-degree murder, causing indignity to a human body, broadcasting obscene material, using the postal service to distribute obscene material, and criminal harassment.15 The publicity surrounding the case prompted a former research assistant to approach police to inform them that, in 2007, he had interviewed Magnotta while working on a study led by Professors Chris Bruckert and Colette Parent, criminologists at the University of Ottawa.16 The Magnotta interview had been conducted as part of a study on the escort industry. The interview had been transcribed and anonymized using the pseudonym “Jimmy.” The researchers had followed meticulous confidentiality protocols in the study, going so far as to have a research assistant sign the participants’ pseudonyms on consent forms so that a comparison of handwriting samples could not result in re-identification.17 When police investigators requested a copy of the Jimmy interview, Bruckert and Parent refused, forwarding it instead to their legal counsel, from whom it was later seized by police on the authority of a search warrant. Bruckert and Parent petitioned to have the search


14 *Ibid* at 52–53.


warrant quashed on the grounds that, as Ogden had argued, information obtained in the context of research is privileged.\textsuperscript{18}

The Quebec Superior Court assessed the admissibility of the Jimmy interview by applying the Wigmore test to Bruckert and Parent’s claim of researcher-participant privilege.\textsuperscript{19} The Crown conceded that the first three Wigmore criteria had been satisfied.\textsuperscript{20} The arguments focused on the fourth criterion, which requires in this case that the court weigh the social value in protecting confidential communications against society’s interest in investigating and prosecuting crime.\textsuperscript{21} The Superior Court held that, in this case, the balance tipped in favour of protecting the confidentiality of the research data given its marginal probative value with respect to the investigation of the alleged crime.\textsuperscript{22} Accordingly, the court quashed the search warrant on the ground that the research interview was protected by researcher-participant confidentiality privilege.\textsuperscript{23}

Although \textit{Parent v R} is the first instance of a Canadian court recognizing the concept of researcher-participant privilege, the decision has not obviated the potential for conflict between ethics and law with respect to judicially compelled disclosure. While the Superior Court recognized the value of human participant research and the importance of confidentiality to the research enterprise, this recognition was accompanied by the proviso that any such claim of privilege would be “situation specific.”\textsuperscript{24} Researchers must continue to be mindful of the possibility that their participants’ data might attract the interest of the legal system. Research institutions, which can expect to share the legal costs of defending research confidentiality, have responsibilities in this area as well, particularly given an interpretation of the TCPS2 2014 issued by the Panel on Research Ethics following the \textit{Parent} decision:

\begin{itemize}
\item \textsuperscript{18} \textit{Ibid.}
\item \textsuperscript{19} \textit{Parent v R}, 2014 QCCS 132, 308 CCC (3d) 493 [\textit{Parent}].
\item \textsuperscript{20} \textit{Ibid} at para 18.
\item \textsuperscript{21} \textit{Ibid} at para 145.
\item \textsuperscript{22} \textit{Ibid} at para 211.
\item \textsuperscript{23} \textit{Ibid} at paras 212, 215.
\item \textsuperscript{24} \textit{Ibid} at para 148.
\end{itemize}
Certain areas of research … are more likely to put researchers in positions where they may experience tension between the ethical duty of confidentiality and disclosure to third parties. … Institutions under whose auspices or within whose jurisdiction such research is being conducted should establish a policy that explains how it will fulfill its responsibilities to support its researchers.25

This raises the questions of what researchers should tell potential participants in their information letters, what research ethics boards (REBs) should advise researchers to tell potential participants, and what policies universities should adopt. Ted Palys and John Lowman, criminologists at Simon Fraser University, have studied these issues extensively. Their many publications exploring these topics span the past two decades.26 In their 2014


monograph, *Protecting Research Confidentiality*, they argue that, in the face of legally compelled disclosure of research data, researchers retain the moral right to protect participant confidentiality over their legal duty to obey the law. Thus the researcher, pursuant to the right of academic freedom and the ethical bond upon which the researcher-participant relationship is based, may opt for an “ethics-first” approach, according to which she may make an unconditional promise of confidentiality to prospective research participants provided that she is prepared to defy a judicial order for disclosure. The alternative is the “law-of-the-land” approach, which conceives of the researcher’s commitment to participant confidentiality as circumscribed by the legal obligation to obey the law, including a judicial order for disclosure of confidential information. Thus a researcher employing the “law-of-the-land” model will qualify a promise of confidentiality by informing potential participants that the confidentiality of their data will be protected only to the extent permitted by law. On this approach, once researchers have exhausted all legal means of resisting judicially compelled disclosure, they must comply with a court order to disclose the confidential data of their participants, and they must warn participants of this possibility as part of the process of obtaining their participants’ informed consent.

Palys and Lowman worry that general adoption of the “law-of-the-land” approach by researchers, and coercive efforts by REBs to steer researchers in that direction, would have a corrosive effect on human participant research, particularly in fields such as criminology and health research. An unconditional promise of confidentiality, they argue, is es-

---

32 Palys & Lowman, *Protecting Research Confidentiality*, supra note 10 at 18–19. See also Bert Black, “Research and Its Revelation: When Should Courts Com-
sential to the conduct of research that may uncover extremely sensitive information.\textsuperscript{33} In the health context, this includes research on “sexual attitudes, preferences, or practices; HIV/AIDS and other STIs; the use of alcohol, drugs, or other addictive products; illegal conduct; psychological well-being and mental health; genetic information, including biological samples stored for future use; [and] epidemiological information.”\textsuperscript{34} Reasonably foreseeable circumstances can arise, particularly in research involving the potential for discovery of illegal activity, in which success in enrolling participants will be contingent on the degree of confidentiality the researcher is prepared to offer. In the case of information concerning very serious criminal activity nothing less than an unqualified promise of confidentiality may do.\textsuperscript{35} According to Palys and Lowman, it is a promise

\begin{footnotesize}
34 Palys & Lowman, \textit{Protecting Research Confidentiality}, \textit{supra} note 10 at 19.
35 There is some experimental evidence that measures the effect of degree and type of promised confidentiality or anonymity on participants’ willingness to disclose personal information. For example, Singer et al found, in a meta-analysis of 113 research reports, that confidentiality assurances result in a statistically significant improvement in response to questions about sensitive data, although the effect is “small” (Eleanor Singer, Dawn R Von Thurn & Esther R Miller, “Confidentiality Assurances and Response: A Quantitative Review of the Experimental Literature” (1995) 59 Public Opinion Q 66 at 67–68, 74); a study of degree of disclosure in studies with anonymous versus non-anonymous methods found no significant difference in response (Maureen Murdoch et al, “Impact of Different Privacy Conditions and Incentives on Survey Response Rate, Participant Representativeness, and Disclosure of Sensitive Information: A Randomized Controlled Trial”, (2014) 14 BMC Med Res Methodol 90 at 1, online: <bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-14-90#Abs1>); in a study of confidential versus anonymous collection methods for obtaining information about substance use, it was found that “the lack of total anonymity in the confidential mode of survey administration does not necessarily impede the same kind of self-reports of alcohol, tobacco and other drug consumption given anonymously” (Roland S Moore & Genevieve M Ames, “Survey Confidentiality vs. Anonymity: Young Men’s Self-Reported Substance Use” (2002) 47:2 J Alcohol Drug Educ 32 at 32); and a study comparing degrees of confidentiality in the collection of personal information (i.e., neutral, confidentially assured, and confidentiality not assured) found no significant difference in disclosure scores across treatment conditions (Bella Ko-
a researcher should be able to make in good faith. In its absence, they argue, the validity, reliability, and integrity of research into legally sensitive areas will be compromised at best and, at worst, thwarted altogether.

In arguing that a researcher retains the moral right to disobey a judicial order for disclosure, they characterize their “ethics-first” approach to research practice as a “civil-disobedience ethic.” While defying compelled disclosure would be an option of last resort, the choice between “ethics-first” and “law-of-the-land” approaches would need to be made in the very earliest stages of research design, as the measures a researcher is prepared to take in order to protect confidentiality must be clearly communicated to participants as part of the informed consent process. Adopting a disposition to civil disobedience might seem an immoderate approach to research, but Palys and Lowman offer a nuanced and multifaceted argument in support of their “ethics-first” approach.

The first strand of their argument exhorts researchers to “Wigmorize” research data by designing research protocols so as to best support a claim of privilege. Although we endorse this recommendation as a reasonable and prudent precautionary measure, in Part I.A we question whether the Wigmore test offers the kind of shield imagined by Palys and Lowman. The second strand of Palys and Lowman’s argument concerns the first criterion of the Wigmore test, which stipulates that privileged communications must originate in a context in which it is clearly enunciated that they will not be

---

bocow, John M McGuire & Burton I Blau, “The Influence of Confidentiality Conditions on Self-Disclosure of Early Adolescents” (1983) 14:4 Prof Psychol Res Pr 435 at 435). In the literature we reviewed, we found no experimental data involving the kind of highly sensitive personal information at the centre of the Ogden or Parent and Bruckert cases (i.e., assisted suicide or participation in the sex trade).

37 Ibid at 18–19; Palys & Lowman, “Ethical and Legal Strategies”, supra note 26 at 74.
38 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 16, 87.
39 Ibid at 17, 289.
40 Ibid at 242.
disclosed.\textsuperscript{41} Palys and Lowman argue that in order to satisfy this criterion, researchers should be careful to avoid the use of qualifying phrases in assurances of confidentiality such as “except as required by law.” Such qualifications might later be interpreted by a court as a waiver of privilege.\textsuperscript{42} While we agree that researchers should avoid any actions or statements that would constitute a waiver of privilege, we argue in Part I.B that the Supreme Court of Canada’s jurisprudence establishes that a limited promise of confidentiality will not necessarily vitiate the first Wigmore criterion. Hence, researchers may, in the interest of full disclosure, alert potential participants to the possibility of compelled disclosure without abandoning any claim to privilege. The third strand of Palys and Lowman’s argument concerns the researcher’s duty to inform participants of reasonably foreseeable risks. They argue that the possibility of court-ordered disclosure does not qualify as such because in the only instances in which researchers have faced judicially compelled disclosure in Canada, the researchers were successful in resisting forced disclosure on the basis of researcher-participant privilege.\textsuperscript{43} In Part I.C, we support Michael Jackson and Marilyn MacCrimmon’s suggestion that case law on informed consent from the health care context might be used to inform the concept of reasonable foreseeability in the research context.\textsuperscript{44} If the analogy with health care is sound, prospective research participants are entitled to be informed of even improbable risks provided that the consequences of those risks are severe.\textsuperscript{45} In our view, the consequences of a court-ordered disclosure of legally sensitive data would rise to that level.

Palys and Lowman might argue that a researcher’s commitment to “ethics-first” civil disobedience would foreclose any risk of disclosure. However, we highlight some practical and philosophical limitations to this position. Civil disobedience may be feasible when the impugned data exists only in the researcher’s mind and has no external representation, whether physical or electronic. Any externally existing data is subject to being forcibly seized by the state (as well as to loss, theft, or accidental discovery). Further, the value of any promise to defy compelled disclo-

\textsuperscript{41} Slavutych, supra note 8 at 260.

\textsuperscript{42} Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 200–01.

\textsuperscript{43} Ibid at 121, 242.


\textsuperscript{45} Ibid.
sure would depend on whether the researcher possesses the psychological capacity to follow through on it, including the fortitude to serve a prison sentence if necessary; this is something that would be difficult for both researcher and participant to ascertain in advance. Moreover, the participant would have no legal recourse should a researcher renge on his or her promise to defy a court order. With these considerations in mind, a potential participant might reasonably balk at an offer of “ethics-first” civil disobedience in defense of personal information. The appeal to civil disobedience is subject to criticism on extra-legal grounds as well, because, as we shall argue, it is not clear that an “ethics-first” approach provides sufficient justice-based reasons to warrant an act of civil disobedience.

Although we use Palys and Lowman’s terms “ethics-first” and “law-of-the-land” throughout, we argue that those employing the so-called “ethics-first” approach have an ethical obligation to tell participants that the confidentiality of their legally sensitive, identifiable data depends on the researcher’s resolve to face the consequences of defying a court order, that participants have no legal recourse if researchers fail in their resolve, and, in the case of identifiable data that exists independently of the researchers, that the researchers cannot guarantee the data will be destroyed before authorities of the state seize it. Without this disclosure, the so-called “ethics-first” approach fails to uphold the ethical principle of informed consent. The so-called “law-of-the-land” approach, by contrast, can comply with all applicable ethical principles, as long as certain measures are taken, as discussed in Part II.

We conclude by setting out our recommendations for researchers and REBs, including the specific steps researchers should take when collecting sensitive data that may be sought by a court or tribunal.

I. “Law-of-the-Land” versus “Ethics-First”: A Critical Analysis

A. The first strand: “Wigmorize” the research data

According to the first strand of Palys and Lowman’s argument, researchers have an ethical responsibility to “Wigmorize” their research data. When data satisfies the four requirements of the Wigmore test, a court will

---

46 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 242.
hold that the data is privileged and therefore inadmissible and immune from forced disclosure. If a court will not order the data to be disclosed, then there is no reason to warn participants about possible limits on confidentiality. Hence, Palys and Lowman recommend that researchers offer their participants unconditional promises of confidentiality once their data is Wigmorized.

The problem with this argument is that fully Wigmorizing research data is beyond the control of researchers. Since, according to the TCPS2 2014, the duty to protect confidentiality is an ethical duty, it would be a breach of that duty for a researcher to promise something that cannot be delivered. Risk of judicially compelled disclosure aside, research confidentiality can be compromised in innumerable ways due to mischief, inattention, or any of the myriad instantiations of Murphy’s Law. Even if a researcher could be reasonably confident that the design of her protocols would meet the first three criteria of Wigmore, the outcome of the case-specific calculus of interests required by the fourth criterion would be unknowable in advance. This is why the Supreme Court of Canada has recognized the impossibility of giving an unconditional guarantee of confidentiality in the context of case-by-case privilege.

47 Gruenke, supra note 5 at 286.

48 Halsbury’s Laws of Canada (online), Evidence, “Privilege and Related Grounds of Exclusion” (VIII.1) at HEV-172 “Overview of Privilege and Related Claims” (2014 Reissue).

49 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 242–43. For earlier exhortations to researchers to Wigmorize their data, see Lowman & Palys, “PRE’s Advisory Opinion”, supra note 26 at 120; Palys & Lowman, “Anticipating Law”, supra note 26 at 5.


51 TCPS2 2014, supra note 2 at 57–58.


The bottom line is that no journalist can give a source a total assurance of confidentiality. All such arrangements necessarily carry an element of risk that the source’s identity will eventually be revealed. In the end, the extent of the risk will
The ease of complying with the first three criteria is illustrated both by the Crown’s concession and by the Court’s analysis in Parent v R. The Crown in Parent conceded that the researchers had met the first three Wigmore requirements. The Court accepted this admission, but went on to explain that it would have found that the first three criteria had been met regardless of the Crown’s admission. It held that the first criterion was met on the basis of the extensive evidence demonstrating that confidentiality was integral to the research project, including the prominent role of confidentiality in the recruitment material, the consent form, the training of interviewers, and the approval granted by the REB. Thus, researchers can meet the first criterion by simply engaging in similar actions to protect confidentiality. The second criterion states that confidentiality must be essential to the relationship at issue. In Parent, the petitioners satisfied this criterion by showing that participants would not have participated in the research if confidentiality had not been guaranteed, because participants would face serious and multiple risks of harm if confidentiality were to be breached. Researchers can ensure compliance with the second criterion by simply documenting the existence of these factors in their own research. The third criterion states that the relationship at issue must be one which “ought to be sedulously fostered.” Here, the relevant relationship is that of researcher-participant. The Court in Parent easily concluded that the researcher-participant relationship ought to be sedulously fostered, given the importance in our democratic society of academic freedom as well as the value of research results in informing public policy, programs, services, and law-making.

only become apparent when all the circumstances in existence at the time the claim for privilege is asserted are known and can be weighed up in the balance.

53 Parent, supra note 19 at para 18.
54 Ibid.
55 Ibid at para 19.
56 Ibid at para 93.
57 Ibid at para 84. See also Gruenke, supra note 5 at 284.
58 Parent, supra note 19 at paras 101–04.
59 Ibid at para 84. See also Gruenke, supra note 5 at 284 [emphasis omitted].
60 Parent, supra note 19 at paras 120, 141.
Thus, academic researchers in a university setting need not re-establish the third criterion; they can simply rely on the analysis in *Parent.*

The fourth criterion, however, is not as straightforward, and, as the Supreme Court of Canada has recognized, it “does most of the work” in the Wigmore analysis. The fourth criterion is the balancing stage, where the court weighs the value of protecting the confidentiality of the data against the public interest in correctly disposing of the litigation at issue. The scales will not always tip in favour of protecting the confidentiality of research data. As Justice Bourque explains in *Parent,* “[t]he public interest in academic freedom is of great importance, but not absolute.” The issue will be decided by “the probative value of the evidence sought … and the nature and seriousness of the alleged wrong-doing,” on the one hand, and

---

61 It should, however, be noted that researchers in a less regulated environment may need to make out their own case. See *National Post,* supra note 52 at para 57:

> The third criterion (that the source-journalist relationship is one that should be “sedulously fostered” in the public good) introduces some flexibility in the court’s evaluation of different sources and different types of “journalists”. The relationship between the source and a blogger might be weighed differently than in the case of a professional journalist like Mr. McIntosh, who is subject to much greater institutional accountability within his or her own news organization. These distinctions need not be canvassed in detail here since the appellants have made out on their evidence, in my opinion, that in general the relationship between professional journalists and their secret sources is a relationship that ought to be “sedulously” fostered and no persuasive reason has been offered to discount the value to the public of the relationship between Mr. McIntosh and his source(s) in this particular case.


63 *Ibid* at para 59. See also *Gruenke,* supra note 5 at 284; *M (A) v Ryan,* [1997] 1 SCR 157 at paras 29, 32, 37, 143 DLR (4th) 1; *Parent,* supra note 19 at para 145.

64 See Wayne Renke, “Researcher Privilege Recognized (This Time): A Comment on *Parent* and *Bruckert v. the Queen*” (2014) 22:3 Health L Rev 5 at 8–9 (recognizing that in future claims of researcher-participant privilege, the first three Wigmore requirements will likely be decided as they were in *Parent,* but that the same cannot be said for the fourth requirement).

65 *Parent,* supra note 19 at para 149.
the public interest in protecting the confidentiality of the data on the other.\textsuperscript{66} Courts must also consider whether the information in question is “available by any other means.”\textsuperscript{67}

The ultimate question underlying these factors is whether protection of confidentiality will result in injustice, as the judge in \textit{Ryan} would not countenance the possibility “that ‘occasional injustice’ should be accepted as the price of the privilege.”\textsuperscript{68} Examples of such injustice include an accused in a criminal proceeding being prevented from answering the Crown’s case, and a defendant in a civil action being prevented from answering the plaintiff’s case.\textsuperscript{69} As such, the scales will tip in favour of disclosure when it is sought by an accused or by a defendant.\textsuperscript{70} Admittedly, an accused’s claim for disclosure is stronger than that of a defendant, because the accused in a criminal proceeding has more to lose, namely, his or her very liberty, as opposed to the money and reputation at stake in a civil action. That being said, the interest of a defendant can still outweigh the value of protecting confidential data, as illustrated by the Supreme Court of Canada’s decision in \textit{M (A) v Ryan}, where the Court ordered the plaintiff’s psychiatrist to disclose a subset of her notes and records to the defendant because they did not satisfy the fourth Wigmore requirement.\textsuperscript{71} Although the interests served in preserving the confidentiality of the communications between the plaintiff and the psychiatrist were compelling,\textsuperscript{72} they were outweighed by the probative value

\textsuperscript{66} \textit{Ibid} at para 145. See also \textit{National Post}, supra note 52 at para 61.

\textsuperscript{67} \textit{Parent}, supra note 19 at para 152. See also \textit{M (A) v Ryan}, supra note 63 at para 37.

\textsuperscript{68} \textit{M (A) v Ryan}, supra note 63 at para 32.

\textsuperscript{69} \textit{Ibid} at para 36.

\textsuperscript{70} For an articulation of this principle as it pertains to an accused in the criminal context, see \textit{Jackson & MacCrimmon}, supra note 44 at 88. Lowman and Palys do recognize that a “defendant’s innocence” will likely override the interest in research confidentiality during the balancing that happens at the fourth criterion: Lowman & Palys, “PRE’s Advisory Opinion”, supra note 26 at 121. However, they argue that because they have not found any cases where research data was sought for the sake of establishing a “defendant’s innocence,” such a scenario does not pose a reasonably foreseeable risk (ibid). For our response to this argument, see Part I.C.1, below.

\textsuperscript{71} \textit{M (A) v Ryan}, supra note 63 at para 41.

\textsuperscript{72} \textit{Ibid} at para 29:
of the communications, given that the communications could bear directly on the issue of liability in the civil action. Specifically, the communications had the potential to exonerate the defendant. While it was not a researcher-participant case, the factors that outweighed privilege in *M (A) v Ryan* would very likely outweigh a claim for researcher-participant privilege. The interests served by the psychiatrist-patient relationship are at least as valuable, if not more so, than the interests served by researcher-participant privilege.

Although disclosure requests by an accused or a defendant are those most likely to succeed, the public interest in investigating crime can also outweigh the value of protecting the researcher-participant relationship. More specifically, thwarting the investigation of crime is another instance of an injustice that courts will not countenance as the price of privilege. For example, in *National Post*, the Crown sought disclosure of an allegedly forged document in order to use forensic analysis such as fingerprint and DNA testing to determine the identity of its author. A majority of the Supreme Court of Canada rejected the National Post’s application to set aside

[The interests served by protecting the communications from disclosure] include injury to the appellant’s ongoing relationship with Dr. Parfitt and her future treatment. They also include the effect that a finding of no privilege would have on the ability of other persons suffering from similar trauma to obtain needed treatment and of psychiatrists to provide it. The interests served by non-disclosure must extend to any effect on society of the failure of individuals to obtain treatment restoring them to healthy and contributing members of society. Finally, the interests served by protection from disclosure must include the privacy interest of the person claiming privilege and inequalities which may be perpetuated by the absence of protection.

73 *Ibid* at para 41.

74 See *ibid* at paras 29, 30 (regarding the interests served by the psychiatrist-patient relationship); *cf Parent, supra* note 19 at paras 120, 130 (the interests served by the researcher-participant relationship “include academic freedom … the pursuit of knowledge and the free flow of ideas,” which contribute to our understanding of the human condition and improving “the social condition of vulnerable and marginalized communities”).

75 See *National Post, supra* note 52 at para 58; *Parent, supra* note 19 at paras 149, 206. Other public interests that can outweigh the value of protecting the researcher-participant relationship include national security and public safety: *National Post, supra* note 52 at para 58; *Parent, supra* note 19 at para 145.

76 *National Post, supra* note 52 at paras 2, 14.
a search warrant for the document.\textsuperscript{77} Not every criminal investigation will vitiate privilege,\textsuperscript{78} but in this case the majority held that the alleged crime was serious.\textsuperscript{79} Perhaps more significantly, the impugned document was not merely a record of reports of alleged criminal activity; it was “the very \textit{actus reus} \textsuperscript{80} [or \textit{corpus delicti}] of the alleged crime.” Given the parallels in the societal interests underlying the journalist-source relationship and the researcher-participant relationship,\textsuperscript{81} the majority’s reasoning in \textit{National Post} would very likely also apply in a research context.

What these cases demonstrate, and what the courts’ reasoning affirms, is that the analysis at the stage of the fourth criterion is situation-specific.\textsuperscript{82} Researchers cannot know at the outset whether their research will meet the fourth criterion, because they cannot know what interests might be weighed against the interest in protecting research confidentiality.\textsuperscript{83} Requests by an

\begin{itemize}
\item \textsuperscript{77} \textit{Ibid} at paras 2–3.
\item \textsuperscript{78} \textit{Ibid} at para 61.
\item \textsuperscript{79} \textit{Ibid} at para 71 (“the dissemination of forged bank entries designed to ‘prove’ an egregious conflict of personal financial interest on the part of the Prime Minister involving public funds is of sufficient seriousness to justify amply the decision of the police to investigate the criminal allegations within the limits of their ability and resources”).
\item \textsuperscript{80} \textit{Ibid} at para 77, citing \textit{R v National Post}, 2008 ONCA 139 at para 115, ACWS (3d) 796 [\textit{National Post}, ONCA].
\item \textsuperscript{81} \textit{National Post}, \textit{supra} note 52 at para 55 (societal interests in the journalist-source relationship include free expression and helping to “fill what has been described as a democratic deficit in the transparency and accountability of our public institutions”). \textit{Cf Parent}, \textit{supra} note 19 at paras 120, 130 (the interests of the researcher-participant relationship include “academic freedom … the pursuit of knowledge, and the free flow of ideas,” which contribute to our understanding of the human condition and to improving “the social condition of vulnerable and marginalized communities”).
\item \textsuperscript{82} \textit{Parent}, \textit{supra} note 19 at para 148.
\item \textsuperscript{83} \textit{National Post}, \textit{supra} note 52 at para 69 (“[i]n the end, the extent of the risk will only become apparent when all the circumstances in existence at the time the claim for privilege is asserted are known and can be weighed up in the balance”). Palys and Lowman acknowledge the truth of this statement (Palys & Lowman, “Anticipating Law”, \textit{supra} note 26 at 11; Palys & Lowman, “Shield Law”, \textit{supra} note 26 at 166). However, they argue that the possibility of a court favouring disclosure of data over protection of research confidentiality is not
accused or a defendant, and requests by the state when the alleged crime is serious, or when the probative value of the impugned data or document is high, or when the data are not available by any other means, will likely override any claim to case-by-case privilege. For these reasons, researchers are not entitled to assume at the outset that their data will meet the fourth Wigmore criterion, and thus they are not entitled to promise unconditional confidentiality on the assumption that they have Wigmorized their data.

In *Parent*, the two key factors at the fourth step were (i) the lack of the data’s probative value, and (ii) the availability of the same information from other, non-confidential sources.\(^84\) Regarding the first of these factors, the Crown anticipated that Magnotta would put forward a defence of not criminally responsible (NCR) on account of mental disorder and that his responses to the research questions “could shed light on [his] mental state.”\(^85\) In assessing this argument, the Court considered the expert opinion of a psychiatrist who had served on the Ontario Review Board where he conducted between 500 and 600 assessments of individuals claiming to be not criminally responsible due to mental disorder.\(^86\) The psychiatrist concluded that the likelihood that the data – the Jimmy interview – would be relevant to the NCR assessment was extremely low.\(^87\) Magnotta gave his responses five years before the alleged crime took place, but most elements of the NCR assessment relate to the accused’s mental state at the time when the crime was committed.\(^88\) The psychiatrist acknowledged a remote possibility that Magnotta’s responses could relate to the first element of the NCR assessment, which is not tied to the time of the crime, and which refers to “the presence or absence of the diagnosis of a mental disorder in the individual.”\(^89\) To resolve this issue, the Court ordered that the data be dis-

\(^84\) *Parent*, *supra* note 19 at paras 145, 177, 186-87, 190–91.

\(^85\) *Ibid* at para 160.

\(^86\) *Ibid* at paras 73–75.

\(^87\) *Ibid* at paras 166–67.

\(^88\) *Ibid* at paras 162, 166.

\(^89\) *Ibid* at paras 162, 165.
closed to the Court. In so doing, the Court was motivated by the seriousness of the criminal offences at issue and the magnitude of the public interest in investigating such a crime. Justice Bourque then read Magnotta’s responses and concluded that all the responses were neither relevant to the first element of an NCR assessment, nor to Magnotta’s state of mind at the time of the alleged crime, nor to the essential elements of the crime. Accordingly, the Court concluded that the potential relevance of the research data was minimal; in other words, it was lacking in probative value. The foregoing discussion illustrates that the Parent decision is only a limited victory for researcher-participant confidentiality. The confidentiality afforded to the research data was not absolute. The Court did in fact order disclosure of the data, albeit on a quite limited scale, namely to the Court alone. Thus, if what Magnotta expected was unconditional confidentiality, he did not get it. In regard to the second factor, namely the availability of the same information from other sources, the Court held that the Crown had access to more relevant contemporary information regarding Magnotta’s mental state that could be used in an NCR assessment. Specifically, the police had gathered information about Magnotta’s personality and lifestyle.

To summarize, the (limited) victory of Professors Bruckert and Parent was not the result of a preference for research confidentiality over the investigation of crime. On the contrary, their victory depended on a nuanced balancing of competing factors. Nothing that Professors Bruckert and Parent did or could have done affected the two factors most salient to the fourth criterion: the probative value of the data and the availability of the same information from other sources. Rather, these particular factors happened to be relevant because of the context of the disclosure request at issue. Researchers cannot assume that their data will satisfy the fourth criterion merely because the data of Professors Bruckert and Parent

---

90 Ibid at para 183.
91 Ibid at para 179.
92 Ibid at paras 186–88.
93 Ibid at para 190.
94 Ibid at para 211.
95 Ibid at paras 169, 177.
96 Ibid at para 191.
did. As such, a promise of unconditional confidentiality issued in anticipation of reasonably foreseeable disclosure requirements, and on the assumption that research data has been Wigmorized, would be inappropriate.

B. The second strand: Does the first Wigmore criterion require an unlimited promise of confidentiality?

The second strand in Palys and Lowman’s argument is the contention that researchers can increase their chances of successfully Wigmorizing their data by promising unconditional confidentiality, because anything less could undermine the researcher’s ability to satisfy the first criterion of the Wigmore test.97 Recall that the first criterion provides that the communications at issue “must originate in a confidence that they will not be disclosed.”98 In support of their argument, Palys and Lowman cite some American decisions where, according to their interpretation, courts ordered disclosure of data on the basis of the limited nature of the promise of confidentiality.

The first of these decisions is Atlantic Sugar v United States.99 In this case, some companies had responded to a questionnaire provided by the International Trade Commission.100 Atlantic Sugar sought and obtained an order for disclosure of the answers to those questionnaires for use in litigation in which it was involved.101 One of the companies that answered the questionnaire brought a motion seeking a stay of the disclosure order until the other companies were given an opportunity to make submissions on the issue.102 The court refused to grant the motion, noting that the questionnaire promised that the responses would remain confidential “except as required by law,” and that the “requirement of disclosure for the purpose of judicial

98 Gruenke, supra note 5 at 284. See also M (A) v Ryan, supra note 63 at para 20; Parent, supra note 19 at para 84.
99 85 Customs Court Reports 128 (Cust Ct 1980), 1980 WL 114432 [Atlantic Sugar cited to Customs Court Reports].
100 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 202.
101 See ibid; Atlantic Sugar, supra note 99 at 128.
102 Atlantic Sugar, supra note 99 at 128.
review is such a requirement.” According to Palys and Lowman, the limitation on the promise of confidentiality embodied in the phrase “except as required by law” created a waiver of privilege.

In the *Re Dolours Price (Boston College)* case, researchers had conducted interviews with former members of the Provisional Irish Republican Army and other political organizations in order to preserve the recollections of individuals involved with the conflict in Northern Ireland known as the Troubles. The interviews took place at Boston College. In 2011, law enforcement authorities from the United Kingdom made a formal request pursuant to the Mutual Legal Assistance Treaty for assistance from the United States with the investigation into the murder of Jean McConville, a suspected British informer. In turn, US authorities issued subpoenas to Boston College for the recordings of the interviews. Boston College and the researchers brought motions seeking to quash the subpoenas, but they were unsuccessful, and interview recordings were eventually turned over to police in the United Kingdom. The Court of Appeals for the First Circuit noted that the agreement with the participants contained a clause restricting access to the interviews until after the death of the interviewees, but that

---

103 Ibid.


106 *Boston College*, *supra* note 105 at 5.

107 Ibid at 3.

108 Ibid at 6.

109 Ibid at 7–8.

this clause did not contain the word “confidentiality.”” 111  In reproducing this passage, Palys and Lowman suggest that the lack of an explicit promise of confidentiality in this clause was a factor in the Court’s decision to uphold the subpoenas.112  In contrast, Palys and Lowman attribute Ogden’s success in meeting the first Wigmore requirement to his promise of unconditional confidentiality.113  The inference to be drawn, presumably, is that researchers should emulate Ogden’s example.114

Palys and Lowman’s reliance on Atlantic Sugar and Boston College suffers from at least two problems. First, neither Atlantic Sugar nor Boston College stand for the principle that a limited promise of confidentiality will undermine researchers’ ability to satisfy the first Wigmore requirement. The courts in those two cases did not even apply the Wigmore framework. In addition, the passage noting the absence of the word “confidentiality” in a clause of the research agreement formed no part of the ratio in Boston College. This passage occurs in the “factual background” section of the decision.115  The majority’s actual reason for upholding the subpoenas was its conclusion that the public interest in law enforcement and unimpeded criminal investigations outweighs any interest in protecting academic confidentiality.116  Far from basing its decision on any limitation to the promise of confidentiality, the majority observed that although Boston College officials recognized the possibility of legally compelled disclosure, the agreements with the research participants did not warn of any potential limits to the promise of confidentiality.117  The majority went on to hold that the unlimited promise of confidentiality could not assist the researchers in this case because, as the majority put it, “the mere fact that a communication was made in express confidence … does not create a privilege…”118  Instead of sup-

111  Boston College, supra note 105 at 5.
112  Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 203.
113  Ibid at 48, 54.
115  Boston College, supra note 105 at 7.
116  Ibid at 16–18.
117  Ibid at 19.
118  Ibid at 19, citing Branzburg v Hayes, 408 US 665 at 682, 92 S Ct 2646, citing Wigmore, supra note 8 at §2286.
porting Palys and Lowman’s argument, the majority’s decision in *Boston College* actually contradicts it.

Second, the Supreme Court of Canada has considered whether a limited promise of confidentiality would undermine the first Wigmore requirement, and, in *M (A) v Ryan*, concluded that it would not. In this case, the plaintiff was sexually assaulted, and then sought counseling from a psychiatrist to address the mental distress caused by the assault. The plaintiff also sued her alleged assailant in a civil action, and he in turn brought a motion to obtain her psychiatrist’s records. A majority of the Supreme Court of Canada granted the defendant’s request and ordered the psychiatrist to disclose to the defendant a subset of her notes and records under specified conditions. The Court held that these notes and records were not privileged, because they did not satisfy the fourth Wigmore requirement. But for present purposes, the significant aspect of the decision is the majority’s holding that the first Wigmore requirement was satisfied, despite the psychiatrist’s warning to the plaintiff that a court might one day order disclosure of her notes and records. In other words, the psychiatrist did not make an unconditional promise of confidentiality to the plaintiff. Rather, she engaged in what Palys and Lowman would call the “law-of-the-land” approach by warning the plaintiff about the possibility of court-ordered disclosure. And yet, the majority held that the first Wigmore requirement was still satisfied. Interestingly, the Master who heard the motion at first instance adopted Palys and Lowman’s perspective insofar as he held that the limitation on the psychiatrist’s promise of confidentiality meant that the first Wigmore requirement was not met. The majority of the Supreme Court of Canada, however, explicitly rejected the Master’s reasoning.

---

119 *M (A) v Ryan*, supra note 63 at para 24.

120 *Ibid* at paras 2–3.


122 *Ibid* at para 41.

123 *Ibid* at paras 28, 29, 41.


125 *AM v Ryan*, 40 ACWS (3d) 730 at para 2, [1993] BCJ No 1234 (QL).

126 *M (A) v Ryan*, supra note 63 at para 24.
The majority’s reason for rejecting the proposition that only an unconditional promise of confidentiality would satisfy the first Wigmore criterion is as follows:

With the possible exception of communications falling in the traditional categories, there can never be an absolute guarantee of confidentiality; there is always the possibility that a court may order disclosure. Even for documents within the traditional categories, inadvertent disclosure is always a possibility. If the apprehended possibility of disclosure negated privilege, privilege would seldom if ever be found.127

By its very nature, case-by-case privilege is not absolute, and so it is impossible to provide absolute guarantees of confidentiality in situations subject to case-by-case privilege. If limited promises of confidentiality necessarily undermine a claim for privilege, then case-by-case privileges would never exist. But the Supreme Court of Canada has repeatedly affirmed that case-by-case privilege does in fact exist.128

Thus, it is not the case that an unconditional promise of confidentiality is needed to satisfy the first Wigmore requirement.129 Nor must researchers promise to defy a court order in order to meet the first requirement.130 As Professors Jackson and MacCrimmon explain, in light of the majority’s decision in M (A) v Ryan, a researcher can overcome the negative impact of a disclosure warning by taking certain steps, which are set out below in Part II.131

127 Ibid. See also National Post, supra note 52 at para 69 (where the Supreme Court stated that absolute guarantees of confidentiality in journalist-source relationships, for which privilege is determined on a case-by-case basis, are impossible).

128 See M (A) v Ryan, supra note 63 at paras 19–20; National Post, supra note 52 at paras 51–53.

129 Palys and Lowman acknowledge the truth of this statement (Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 199–200, 206). And yet they continue to appeal to the need to satisfy the first Wigmore criterion in support of their “ethics-first” approach (ibid at 201–03).

130 Jackson & MacCrimmon, supra note 44 at 80.

C. The third strand: Is court-ordered disclosure reasonably foreseeable?

1. Which risks are reasonably foreseeable?

As argued in Part A above, some research data will fail to satisfy all four of the requirements of the Wigmore test. Palys and Lowman do not view this as a problem for their argument, because they believe that the possibility of a court ordering disclosure of research data in Canada is so remote that it cannot be considered “reasonably foreseeable” for the purposes of securing informed consent. While the TCPS2 2014 stipulates that researchers must warn potential participants of “reasonably foreseeable” disclosure requirements, Palys and Lowman argue that the possibility of a court upholding a subpoena or search warrant for the disclosure of research data falls short of this threshold. In their view, the probability of such an eventuality does not qualify as “reasonably foreseeable.” If an event is not reasonably foreseeable, then researchers have no obligation to warn prospective participants about it.

In support of this argument, Palys and Lowman note that, of all the research ever conducted in Canada, only twice has a state body tried to access confidential research data: first from Ogden and then from Bruckert and Parent. The lynchpin in their argument is the utter lack of court-ordered disclosure of confidential research data in Canada. Of those researchers who have received disclosure requests in Canada, none have been required to comply with such requests. In both Ogden’s case and the case of Professors Bruckert and Parent, the researchers won; the respective tribunals held that the data was privileged, and the researchers were not required to disclose it. For Palys and Lowman, this means that “[t]he odds are probably greater that a research participant will be involved in a road accident on his or her way to an interview appointment.” But of course, no researchers include such a warning in their information letters or consent forms.

---

132 Jackson & MacCrimmon, supra note 44 at 121.
134 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 121.
135 Ibid at 242.
136 Ibid at 103, 121, 286.
137 Ibid at 103; Parent, supra note 19 at paras 213–16.
138 Ibid at 242.
This raises the question: what does it mean for a risk to be “reasonably foreseeable”? The TCPS2 2014 provides examples of reasonably foreseeable risks, but it does not suggest a test to define the concept.\textsuperscript{139} Palys and Lowman’s conception of “reasonable foreseeability” is limited insofar as it recognizes only the probability of an event, but not its seriousness.\textsuperscript{140} This is an issue in respect to which Jackson and MacCrimmon offer useful guidance as their conception of reasonable foreseeability incorporates both the probability of an event and the seriousness of its consequences.\textsuperscript{141} In support of their view, Jackson and MacCrimmon rely on jurisprudence on the doctrine of informed consent in the health care context\textsuperscript{142} to flesh out what it means for a risk to be “reasonably foreseeable” in the research context.\textsuperscript{143} According to the doctrine of informed consent under Canadian common law, a physician has a duty to disclose all material risks of treatment in order to obtain the patient’s informed consent to that treatment.\textsuperscript{144} Courts use an

\begin{footnotesize}
\textsuperscript{139} See e.g. TCPS2 2014, supra note 2 at 61 (“research that involves interviewing high-risk families about intergenerational violence raises a reasonably foreseeable prospect that researchers may acquire information that a child is being abused”).

\textsuperscript{140} Note, however, that Palys and Lowman do give one indication that the seriousness of the consequences informs their conception of a researcher’s disclosure obligation: “In research like Ogden’s, where the potential harms of disclosure to a participant are substantial, the risk of a court order for disclosure should be raised, along with a statement by the researcher about what he or she will do if that were to occur” (Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 103–04). And yet, in the same paragraph, they seem to suggest that the prospect of a criminal conviction for a crime other than murder would not be substantial enough to warrant warning prospective participants about possible court-ordered disclosure (\textit{ibid} at 103).

\textsuperscript{141} See Jackson & MacCrimmon, supra note 44 at 12–13, 113.


\textsuperscript{143} Jackson & MacCrimmon, supra note 44 at 12–13, 113.

\end{footnotesize}
objective standard to assess whether a risk is material. They ask whether a reasonable person in the patient’s position would want to know about the risk. Material risks include those that are remote but would entail serious consequences, such as death or paralysis. Put another way, even “an ‘unusual’ or improbable risk should be disclosed if its effects are serious.” A reasonable person would want to know about risks involving grave consequences even when the probability of the occurrence of such risks is low.

Employing the concept of material risk in the research context means that a researcher has a duty to warn prospective participants about the kinds of risks that a reasonable person would want to know about when deciding whether to participate in research. If, for example, participation in a particular study involves a risk that police may seize the raw data in order to lay criminal charges against the participant, then the researcher has an obligation to warn about this risk, even if it is remote. Given the grave consequences of a criminal conviction or a finding of civil liability, it is arguable that a reasonable person would want to know about such a risk.

Using the concept of material risk to inform the meaning of reasonable foreseeability in the research context is compelling for at least the following three reasons. First, this approach is consistent with the jurisprudence on a researcher’s duty to disclose. Canadian courts have held that a researcher’s disclosure obligation, like that of health practitioners, is assessed according to an objective standard. Researchers must disclose all risks that a reasonable person in the prospective participant’s position would want to consider. The difference between researchers and health practitioners is that

---

145 See Hopp v Lepp, supra note 144 at 209; Ciarlariello v Schacter, [1993] 2 SCR 119 at 133, 100 DLR (4th) 69.

146 See Hopp v Lepp, supra note 144 at 208; Ciarlariello v Schacter, supra note 145 at 133; Halsbury’s, Medicine and Health, supra note 144 at HMH-73.

147 See Hopp v Lepp, supra note 144 at 209; Reibl v Hughes, supra note 144 at 884–85; Halsbury’s, Medicine and Health, supra note 144 at HMH-73. See also McGivern & Ivolgina, supra note 142 at 142.


149 See Jackson & MacCrimmon, supra note 44 at 113.

150 See e.g. Halushka v University of Saskatchewan (1965), 53 DLR (2d) 436 at 443, 52 WWR 608 (Sask CA).
the standard of disclosure imposed on researchers is *higher* than the standard imposed on health practitioners:

> In my opinion the duty imposed upon those engaged in medical research … to those who offer themselves as subject for experimentation … is at least as great as, if not greater than, the duty owed by the ordinary physician or surgeon to his patient. There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment against the risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research. The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent.\(^\text{151}\)

The Supreme Court of Canada affirmed this passage in *obiter* in *Hopp v Lepp*.\(^\text{152}\) The higher disclosure standard for researchers supports the proposition that researchers have an obligation to warn about even low-probability risks that have serious consequences.

Second, the Interagency Advisory Panel on Research Ethics confirms this approach in its 2007 interpretation of the first *Tri-Council Policy Statement*, entitled “Researchers and the Duty to Warn: Limits on the ‘Continuum of Confidentiality?’”\(^\text{153}\) In this interpretation, the Panel endorses an objective standard insofar as it recommends that informed consent should be understood from the perspective of a reasonable prospective participant: what information would a reasonable prospective participant want to know in deciding

\(^{151}\) *Ibid.*

\(^{152}\) *Hopp v Lepp*, *supra* note 144 at 205–06.

whether to participate in research? The Panel’s answer is that a reasonable person would want to know about any limits on the confidentiality of his or her data, such as the possibility of court-ordered disclosure of that data.

Third, this approach upholds one of the foundational values underpinning the TCPS2 2014: the principle of respect for persons, which implies respect for autonomy. The principles of respect for human dignity, persons, and autonomy provide the conceptual foundation for informed consent as defined by the TCPS2 2014. Warning participants about the possibility of court-ordered disclosure of their data ensures that their consent to participate in research is truly informed. The significance of these principles is not merely theoretical; Steven Picou reports that one of his research participants committed suicide when the Exxon Corporation sought identifiable data Picou had collected for his research about stress levels and social disruption as a result of the Exxon Valdez oil spill in Alaska in 1989. The Exxon Corporation sought to use the data in litigation concerning damages from the oil spill. Participants had been “guaranteed confidentiality”; from this it can be inferred that they were not warned about the possibility of court-ordered disclosure of their identifiable data. It is not surprising, then, that Chapter 3 of the TCPS2 2014 states that to obtain informed consent, a researcher must provide “information indicating who may have a duty to disclose information collected, and to whom such disclosures could be made.” Researchers can perhaps most reasonably address this requirement by borrowing the concepts of informed consent and material risk from the health care context and applying them to the research context.

In response to this critique, Palys and Lowman might reply that, even if a court does order disclosure of a participant’s data, the possibility of discl-
sure still does not constitute a reasonably foreseeable risk, because the researcher can refuse to disclose the data.\footnote{Palys & Lowman, \textit{Protecting Research Confidentiality}, supra note 10 at 245–46.} And, if no disclosure of data will occur, then there is no risk about which participants must be warned. This – the final bulwark of their argument – is the appeal to civil disobedience.\footnote{Palys & Lowman, \textit{Protecting Research Confidentiality}, supra note 10 at 17, 289.} The researcher can defy a court order and accept the consequences,\footnote{\textit{Ibid} at 246.} which could include incarceration for being held in contempt of court.\footnote{For an earlier articulation of Palys and Lowman’s recognition of researchers’ willingness to serve jail time in order to protect research confidentiality, see Palys & Lowman, “Defending Research Confidentiality”, \textit{supra} note 26 at 272.} Palys and Lowman are not the sole defenders of this course of action: it also enjoys the support of the American Sociological Association’s Committee on Professional Ethics,\footnote{Palys & Lowman, \textit{Protecting Research Confidentiality}, supra note 10 at 250–51.} among others.\footnote{See e.g. Wolfgang, \textit{supra} note 1 at 353.} Further support for this position, moreover, might arguably be found in a response from the Committee’s Chair who explained that an academic is entitled to promise potential research subjects unlimited confidentiality as long as the academic is willing to back up that promise by defying any court order to disclose data and by accepting the consequences of such defiance, including a sentence of jail time.\footnote{Palys & Lowman, \textit{Protecting Research Confidentiality}, \textit{supra} note 10 at 251. But note that the American Sociological Association has also made the following statement: “[I]t is also important that all consent forms and processes, and research protocols be designed and administered to describe clearly the limits on confidentiality so that the subjects fully comprehend these limits in determining their participation” (Panel on Research Ethics, “Researchers and the Duty to Warn”, \textit{supra} note 153 at para 32, citing American Sociological Association, “Issues in Confidentiality and Research Data Protections: A Report and Draft Recommendations to NHRPAC Social and Behavioral Sciences Working Group”, in National Human Research Protections Advisory Committee, \textit{Recommendations on Confidentiality and Research Data Protections} (Rockville, Maryland: NHRPAC, 2002) at 4).}
2. Practical limitations of a civil disobedience ethic

A researcher’s ability to resist compelled disclosure is subject to certain practical limitations. Palys and Lowman recommend that researchers personally maintain care and control of their data, in order to prevent the university from turning over the data when requested to do so by state authorities, but police are authorized to use force in executing a search warrant. Unless a researcher intends to return force with force, a mere refusal to turn over data will be futile.

Alternatively, a researcher might plan to destroy the data on learning of a search warrant or on receiving a summons in civil litigation. In such an event, fighting off the police with force would be unnecessary, because the data would cease to exist before a state authority tried to seize it. Of course, researchers would face legal consequences for destroying data in the face of a search warrant or summons, but a researcher acting on an “ethics-first”

---


170 *Savinkoff v Borodula* (1957), 13 DLR (2d) 131 at 138, 120 CCC 165 (BCSC) (officers may use reasonable force and ingenuity in executing a search warrant); *R v Kong Yick* (1918), 25 BCLR 269 at 269–70, 33 CCC 86 (SC) (the power to enter under a warrant includes the power to “[break] open” and “use force”, and the inclusion of these words in the warrant are unnecessary). In the Bruckert and Parent case, police seized the transcript of the Magnotta interview from the office of Bruckert and Parent’s lawyer (Shuchman, supra note 16 at 250).

171 Note that an exception exists when the data has no external existence (for example, in the form of paper or digital recordings), but rather exists solely in the researcher’s mind. This may occur, for example, when a researcher has interviewed participants in person but not collected or recorded any identifiable information, such as the participants’ names. In this case, a mere refusal to disclose information would be effective, as was the case with Russel Ogden.

172 Such consequences could include being charged with disobeying a court order pursuant to section 127 of the *Criminal Code*, which is punishable by up to two years’ imprisonment (RSC 1985, c C-46), or with obstruction of justice pursuant to subsection 139(2) of the *Criminal Code*, which is punishable by up to ten years’ imprisonment (*ibid*). Rule 60.11(5) of Ontario’s *Rules of Civil Procedure* sets out a wide range of possible consequences for a finding of contempt in the civil context, including imprisonment “for such period and on such terms as are just,” paying a fine, paying the legal costs of other parties, or “any other order that the judge considers necessary” (RRO 1990, Reg 194). If the
disposition to civil disobedience might be prepared to accept the consequences, presumably even if it means serving time in jail.  

However, this strategy will prove ineffective in many circumstances. Granted, it could succeed in a civil context where the researcher receives a summons instructing him or her to provide documents at an examination for discovery or in court. In this type of situation, the researcher has notice of the disclosure request and thus the opportunity to destroy the data. But that same opportunity will rarely exist in the criminal context. Most search warrants are issued ex parte, that is, without notice to the party subject to the search warrant. The rationale for this practice is not difficult to fathom: police will seldom succeed in obtaining criminal evidence if they warn suspected criminals about their search ahead of time. Although a judge issuing a search warrant may, in some circumstances, order that notice be given to the affected party, doing so is generally a matter of the judge’s discretion. A judge will decline to make such an order when faced with the risk that the evidence will be “made to disappear.” Such a risk would exist when researcher is a party to civil litigation, then she or he may also be subject to the consequences associated with spoliation. See Marie-Andrée Vermette, “Spoliation and Sanctions for the Failure to Preserve Relevant Documents in Canada” in Bryan Finlay, Marie-Andrée Vermette & Michael Statham, eds, Electronic Documents: Records Management, e-Discovery and Trial (Toronto: Canada Law Book, 2010) (loose-leaf) 5-29.

Although researchers in Canada have thus far avoided this fate, researchers in the US have been less fortunate. In 1972, Samuel Popkin was imprisoned for refusing to disclose confidential research data to a grand jury: James D Carroll & Charles R Knerr, “A Report of the APSA Confidentiality in Social Science Research Data Project” (1975) 8:3 PS 258 at 258. Similarly, Rik Scarce spent 159 days in jail for refusing to disclose research data (Rik Scarce, “Scholarly Ethics and Courtroom Antics: Where Researchers Stand in the Eyes of the Law” (1995) 26:1 The American Sociologist 87 at 94–96). Lowman and Palys also draw an analogy between researchers and journalists, and note the willingness of some journalists to serve jail time for the sake of protecting their sources. For example, “American journalist Judith Miller … spent 85 days in jail in 2005 for refusing to name a White House source who leaked the identity of a CIA agent” (Lowman & Palys, “PRE’s Advisory Opinion”, supra note 26 at 121).

See e.g. Rules of Civil Procedure, supra note 172, r 34.10(3), 53.04(1).

See National Post, supra note 52 at para 80.

Ibid at para 83.

Ibid.
the subject of the warrant has made prior statements extolling the virtues of defying court orders, especially statements published in a highly public forum such as a book, an academic journal, or a research consent form.

Even when defying a court order is feasible, such a course of action is subject to further limitations. If we use the notion of material risk to understand the concept of informed consent, then researchers are obligated to inform participants that the promise of confidentiality rests on the researchers’ willingness to pay the price for defying a court order, such as by serving time in jail.\textsuperscript{178} In other words, merely telling prospective participants that their data will remain confidential, even if a state authority seeks disclosure of that data, is not sufficient. A reasonable prospective participant would want to know that the confidentiality of his or her data depends on the researcher’s resolve to choose incarceration over compliance with compelled disclosure. Participants are entitled to assess for themselves the likelihood of a researcher actually upholding such a promise.\textsuperscript{179}

There may be a certain romantic appeal to the notion of serving jail time for the sake of principle, but the appeal as well as the commitment may vanish when the possibility no longer seems remote. In that event, researchers may find that they are simply not psychologically capable of following through on their promise. Aside from the considerable psychological adjustment required by prison life, there are onerous natural consequences involved in being removed from society. For example, generally speaking, an employer is not required to hold an employee’s job while that person serves

\textsuperscript{178} See Geoffrey R Stone, “Above the Law: Research Methods, Ethics, and the Law of Privilege”, Discussion, (2002) 32:1 Sociol Methodol 19 at 23 (arguing that, in the absence of an unequivocal legal recognition for researcher-participant privilege, it is unethical for researchers to promise absolute confidentiality without informing participants that the researchers will need to break the law in order to uphold that promise).

\textsuperscript{179} In Protecting Research Confidentiality, Palys and Lowman do not state that participants should be warned that the confidentiality of their data may depend on the researcher’s willingness to defy a court order and potentially go to jail. They merely advocate that researchers make an unambiguous promise of confidentiality and then keep it (\textit{supra} note 10 at 243). In “Subject to the Law,” in contrast, Lowman and Palys argue that there is no deception involved in their approach; stating that participants “should be informed about the nature of the law and the researcher’s position regarding it,” such that participants can decide whether they trust the researcher to maintain the promise of confidentiality (\textit{supra} note 26 at 387).
Serving a prison sentence, then, may require considerable personal sacrifice. If confidentiality depends on whether a researcher has the moral fibre to make this sacrifice, this is a material fact that a prospective participant is entitled to know so that the participant may assess for himself or herself the likelihood that a researcher will follow through on such a promise.

Merely explaining to a potential participant that the confidentiality of their data depends on the willingness of the researcher to go to jail, however, is still not sufficient to uphold the principle of informed consent because a promise to defy a court order, even if made explicit in an information letter, is problematic for an additional reason. As Jackson and MacCrimmon explain, such a promise may be misleading if a participant believes that it carries some legal weight, because courts will not enforce such a promise. If a researcher reneges on his or her promise to defy a court order, participants are left with no legal remedy. Contracts that are contrary to public policy are legally unenforceable, and a contract to commit a criminal offence is a clear example of a contract that is contrary to public policy. As mentioned above, disobeying a court order and obstruction of justice are criminal offences pursuant to sections 127 and 139(2) of the Criminal Code respectively. Even if a researcher’s refusal to obey a court order does not rise to the level of one of these criminal offences, the researcher’s promise would likely still constitute a contract to interfere with the administration of justice, which is another example of a contract that is contrary to pub-

An exception would exist if the employment contract or collective agreement provides otherwise. This, however, is extremely rare. Aside from the fact that most academics do not have enough bargaining power to hold out for a provision stipulating that their salary will be paid while they are incarcerated, very few would think to request such a provision.

Jackson & MacCrimmon, supra note 44 at 135.

Ibid.


Supra note 172.
Thus, in order to fully comply with the principle of informed consent, researchers must tell participants not only that the confidentiality of their data depends on the researchers’ willingness to go to jail, but also that, if the researcher reneges on that promise, the participants will have no legal recourse.

In response, Palys and Lowman state:

[It] would be a mistake to conceptualize a research-ethics policy purely in legalistic terms, hence our writing this book. The conceptualization of the researcher-participant relationship as a ‘contract’ may be appropriate for some biomedical research, but it makes much less sense in qualitative field research, particularly that which is community based, where the researcher-participant relationship depends on empathy and trust rather than the legal concept of contract.

Participants involved in criminology research may not view their relationship with researchers as a contractual one. Thus, it may not come as a disappointment to them to learn that they are without legal remedy should researchers renge on their promise to defy a court order. If participants have no expectation of being able to legally enforce the researcher’s promise to go to jail, then there is no reason to warn them that such a promise is legally unenforceable. However, the claim that participants have no expectation of being able to legally enforce such a promise is an empirical one, and, as such, is subject to confirmation or refutation. The information letter and the consent form are the best empirical indicators of a participant’s expectations regarding the research relationship. To demonstrate that a participant truly does not expect to be able to use legal remedies, the researcher should include such a statement in the information letter/consent form. This brings us back to the proposition that, when an information letter promises that a researcher will defy a court order, it should also explain that if the researcher reneges on this promise, the participant would have no legal recourse. In this way, researchers can provide empirical proof that their participants do not conceive of their relationship as a contractual one.

---


The problem with such a warning is that it is unlikely to achieve the desired effect. Palys and Lowman’s purpose in advocating for an unconditional promise of confidentiality is to support valid and reliable research.\textsuperscript{188} Their concern is that potential participants will not enroll in research studies if their data is subject to court-ordered disclosure, or, if they do enroll in such studies, their responses will be less than fully forthcoming.\textsuperscript{189} Thus, Palys and Lowman urge that participants must be promised absolute confidentiality. But it turns out that, in order to comply with the requirements of informed consent, this so-called promise of absolute confidentiality actually amounts to no more than a promise to defy a court order and go to jail, along with a warning that if the researcher changes his or her mind and discloses the data in order to avoid jail, the participant will have no legal means to enforce the researcher’s promise. It is not clear that such a limited promise will encourage potential participants to take part in the research, or that it will enhance the validity and reliability of research results.

3. Civil disobedience: Some philosophical considerations

In practice, adopting an “ethics-first” approach to human participant research would mean privileging the obligation to maintain participant confidentiality over the legal duty to comply with a judicial order for disclosure. Thus, Palys and Lowman characterize their “ethics-first” approach to

\textsuperscript{188} Palys & Lowman, “Ethical and Legal Strategies”, \textit{supra} note 26 at 74; Palys & Lowman, “Shield Law”, \textit{supra} note 26 at 163.

\textsuperscript{189} Palys & Lowman, “Shield Law”, \textit{supra} note 26 at 169. As discussed above, the existing academic literature assessing the effect of promises of confidentiality on the quality of participants’ responses does not address the kind of highly sensitive personal information at the center of the Ogden or Bruckert and Parent cases (i.e., assisted suicide or participation in the sex trade). See \textit{supra} note 35. That being said, there is some anecdotal evidence, which has received judicial support, in support of the notion that participants need an unconditional guarantee of confidentiality before they will disclose such highly sensitive information. In \textit{Parent}, Justice Bourque found as fact that the ability of Bruckert and Parent to undertake research on sex work would be jeopardized if confidentiality had not been upheld in that case (\textit{Parent, supra} note 19 at para 205). In reaching this conclusion, Justice Bourque accepted Bruckert’s evidence that the majority of her participants would not have participated in the research without a “binding promise of confidentiality” and that without a binding promise of confidentiality, at least one participant would be less than forthcoming when responding to research questions (\textit{ibid} at paras 203–04).
research practice as a “civil disobedience ethic.”\textsuperscript{190} However, implicit in the “ethics-first” approach are controversial assumptions about the relationship between ethics and the law that remain unexamined in Protecting Research Confidentiality.

A useful discussion of principled noncompliance with the law is found in John Rawls’ \textit{A Theory of Justice}, where civil disobedience is defined as “a public, nonviolent, conscientious yet political act contrary to the law usually done with the aim of bringing about a change in the law or policies of the government.”\textsuperscript{191} Rawls acknowledges that his definition owes much to a tradition that goes back to HA Bedau and Martin Luther King.\textsuperscript{192} It is a definition that accommodates civil disobedience in political contexts\textsuperscript{193} approximating Rawls’ “nearly just society” as “one which is well-ordered for the most part but in which some serious violations of justice nevertheless do occur.”\textsuperscript{194} What would distinguish defensible acts of civil disobedience from contempt for the law are their implicit appeal to a “public conception of justice.”\textsuperscript{195} In other words, civil disobedience is a kind of political theatre that serves the cause of legal reform by drawing public attention to a palpable injustice in the law, an injustice which will qualify as such by that same public’s standards of fairness.

This is why Ronald Dworkin suggests that to engage in genuine civil disobedience is to “accept the fundamental legitimacy of both government and community.”\textsuperscript{196} But Dworkin offers a broader and more nuanced definition of civil disobedience than that found in Rawls by making room for a distinction between “integrity” and “justice-based” forms. Both are motivated by “convictions of principle”;\textsuperscript{197} the former is a matter of conflict

\begin{footnotesize}
\begin{enumerate}
\item Palys & Lowman, \textit{Protecting Research Confidentiality}, supra note 10 at 289.
\item \textit{Ibid}, n 19.
\item Rawls, \textit{supra} note 191 at 363.
\item \textit{Ibid} at 365.
\item \textit{Ibid} at 107.
\end{enumerate}
\end{footnotesize}
between the law and one’s deeply held personal values, while the latter is a matter of Rawlsian defiance of the law in the interest of a public conception of justice.

Principled noncompliance raises important and vexing questions about when, and to what extent, a civil society should tolerate exceptions to the democratic and constitutional principle of equality before the law. But neither of Dworkin’s concepts of principled civil disobedience would be a natural fit for a researcher looking for a principled basis upon which to disobey a judicial order for disclosure. Nowhere do Palys and Lowman suggest that Canadian law pertaining to privilege and the admissibility of evidence is oppressive, unjust, or illegitimate – or indeed that the judicial system is procedurally or structurally flawed in a way that we might reasonably expect its decisions around such issues to be compromised. Thus their conception of ethics-first does not comply with Dworkin’s justice-based criteria for defensible civil disobedience. Disclosure of research data would normally be sought in the interest of securing a fair trial, and would therefore be compelled in the interest of justice. In the absence of substantive concerns about the law or its administration, the researcher’s decision not to comply would be based on nothing more than a difference of opinion concerning the relative value of the research enterprise versus the interest justice has in determining the truth. As Geoffrey Stone observes, “there is no ethical basis for [civil disobedience] merely because citizens, courts and legislators don’t do what scholars think is in their best interests.”

If Palys and Lowman’s notion of “ethics-first” non-compliance falls short of Dworkin’s justice-based civil disobedience, neither does it lend itself to the integrity-based alternative. The values informing “ethics-first,” particularly that of participant confidentiality, are part of conventional ethical research standards as codified in the TCPS2 2014, a document which the social science and medical research communities in Canada recognize as authoritative. As Palys and Lowman illustrate in their analysis of case law relevant to the protection of confidentiality, courts in Canada and the US

198 If Palys and Lowman were to take such a position, then before engaging in “civil disobedience,” they would be obligated to “make a serious and sustained effort within our political and legal system to educate and persuade voters, courts, and legislators to enact such a privilege as essential to the ability of researchers and universities to fulfill their responsibilities to society” (Stone, supra note 178 at 24 [emphasis omitted]).

199 Ibid at 2.
have generally been supportive of the values of participant confidentiality, the social utility of research, and the principle of researcher privilege.

Palys and Lowman’s ethics-first approach to the protection of participant confidentiality, and their characterization of it as a civil disobedience ethic, is based on the assumption that circumstances may arise in which the researcher’s ethical duty to the protection of participants should override the legal duty to comply with compelled disclosure. However, the contrast they draw between “ethics-first” and “law-of-the-land” invites the possibility that the duty to obey the law might qualify as an ethical duty as well. In that case it would not be a matter of ethics versus the law, but of competing ethical duties. Some laws compel us to do what would be morally obligatory in their absence: those prohibiting assault, fraud and theft being obvious examples. However, much of the law serves the function of social coordination rather moral sanction. For example, there is no ethical reason why we should drive on the right hand side of the road rather than the left, but the existence of such a rule facilitates the safe flow of traffic. If “justice” is an ethical value, as might reasonably be argued, a subpoena might imply an ethical duty to comply. To summarize, it is not clear that the “ethics-first” approach provides ethically principled justification for “civil disobedience” in the face of a judicial order for disclosure.

II. IMPLICATIONS FOR RESEARCHERS AND RESEARCH ETHICS BOARDS

Researchers can promise unconditional confidentiality in good faith only when they can collect research data anonymously. The courts cannot seize what never existed. It is important to distinguish between “anonymous information” as defined by the TCPS2 2014, which is information that “never had identifiers associated with it,” and “anonymized information,” which is information that included identifiers when obtained, but was later de-identified. Regarding the former, researchers and REBs should con-
sider carefully whether the information in question truly never had identifiers associated with it.\(^{203}\) Regarding the latter, researchers cannot guarantee that identifiable information will be safe from state seizure during the time between collection of data and its anonymization.

A survey conducted online may appear to be an anonymous data collection method, but online sources can be linked to participants through Internet Protocol addresses or by using personal details that may emerge in responses to survey questions. Paper-based surveys avoid this problem but carry their own risks. In *R v National Post*, for example, the Supreme Court of Canada upheld a search warrant authorizing police to seize a confidential document and envelope provided by a source to the National Post. The purpose of seizing the document and envelope was to conduct forensic testing – specifically to identify fingerprints or to extract a DNA sample from potential saliva remnants – in order to identify the author of the document.\(^{204}\) Admittedly this situation is not likely to arise in a research context. A key factor in the majority’s reasons in *R v National Post* for deciding that the document was not privileged was that the document was “the very *actus reus* [or *corpus delicti*] of the alleged crime.”\(^{205}\) One is hard-pressed to imagine how responses to a research survey could become the *actus reus* or *corpus delicti* of a crime.\(^{206}\) But the example of *National Post* should alert us to the fact that common assumptions about the security of data-gathering methods can be seriously mistaken, particularly in the area of forensic technology. Furthermore, in order to uphold a promise of confidentiality, each member of a research team must be equally committed. This was made clear in *Parent* where the only reason police had an interest in data held by Professors Bruckert and Parent was that their undergraduate research assistant took it upon himself to inform the police about the Jimmy interview.\(^{207}\)

---

\(^{203}\) *Ibid.*

\(^{204}\) *Supra* note 52 at paras 21, 91.

\(^{205}\) *Ibid* at para 77, citing *National Post, ONCA*, supra note 80 at para 115.

\(^{206}\) Admittedly, such a situation might occur if a response to the research survey amounts to hate propaganda pursuant to sections 318 or 319 of the *Criminal Code*, supra note 172. Note, though, that section 319 contains the additional requirement that the impugned statement occur in a “public place.”

\(^{207}\) *Parent, supra* note 19 at para 25.
Some research will not allow anonymous collection of data. As discussed above in Part I.A, we are less sanguine than Palys and Lowman about the prospects for protecting confidentiality through attempts at Wig-morizing it. What might be required to satisfy the fourth Wigmore criterion cannot be anticipated by researchers because it cannot be known in advance what kind of legal exigencies will be weighed against the public interest in fostering human participant research.

We recommend, following Jackson and MacCrimmon, that in order to respect the dignity and autonomy of the participant and to uphold his or her right to give informed consent, researchers should warn participants about the possibility of compelled disclosure whenever this risk is reasonably foreseeable.²⁰⁸ Making this warning part of the informed consent process could weaken a prospective claim to researcher-participant privilege, but as Jackson and MacCrimmon explain, in light of the majority’s decision in M (A) v Ryan there are measures a researcher can take to reduce the potentially negative implications of a warning of potential disclosure.²⁰⁹ First, in the information/consent letter, researchers should document the importance of confidentiality to the participant’s decision to participate in the research.²¹⁰ This recommendation follows from the majority’s conclusion in M (A) v Ryan that the plaintiff’s request to her psychiatrist that her communications remain confidential served to mitigate the effect of recognizing the possibility of forced disclosure.²¹¹ One way to meet this recommendation is to state in the information/consent letter that the participant would not have agreed to participate in the research without the promise of confidentiality. This brings us to the second step: the researcher and the university should promise to take every legally permissible action to protect the participant’s confidentiality.²¹² This recommendation follows from the majority’s conclusion in M (A) v Ryan that the psychiatrist’s promise that she would do everything

²⁰⁸ See Jackson & MacCrimmon, supra note 44 at 121 (setting out model language that may be used in information/consent letters). For recommendations pertaining to this issue in the American context, see Carroll & Knerr, supra note 173 at 260–61.

²⁰⁹ Jackson & MacCrimmon, supra note 44 at 106–07, citing Jones, supra note 131 at 7–8.

²¹⁰ Jackson & MacCrimmon, supra note 44 at 106–07.

²¹¹ M (A) v Ryan, supra note 63 at para 24.

²¹² Jackson & MacCrimmon, supra note 44 at 106–07, citing Jones, supra note 131 at 7–8.
possible to keep the plaintiff’s communications confidential helped to mitigate the warning to the plaintiff about the possibility of forced disclosure.\textsuperscript{213}

The promise to do “everything possible” to protect confidentiality needs to be fleshed out if such a promise is to be found to be persuasive by the courts and to respect the principle of informed consent. Researchers should specify the precise steps they will take in the face of compelled disclosure. If researchers are prepared to challenge any search warrant or subpoena, and if the university will financially support such efforts, including any necessary appeals, then the information/consent letter should make this clear.\textsuperscript{214} To the extent that researchers and universities are not prepared to make these promises and keep them, the likelihood of satisfying the first Wigmore requirement diminishes. The interpretation issued by the Panel on Research Ethics (PRE) in April 2014 supports this approach. It advises universities to establish policies setting out the steps they will take in response to an attempt to legally compel disclosure of confidential research data. Researchers and their participants need to know what institutional policies support article 5.1 of the \textit{TCPS2 2014}, which states that: “Institutions shall support their researchers in maintaining promises of confidentiality.”\textsuperscript{215} The PRE’s directive goes on to specify that such a policy “should include an explanation of the nature and the scope of the support, a mechanism to determine the level of support in individual cases, the source of funding (e.g., dedicated fund, insurance, agreement with professional association) and any other relevant criteria.”\textsuperscript{216} Researchers must know this detailed information in advance before communicating it to prospective participants. This information, and its communication in the consent process, would allow researchers to mitigate the potentially negative effects of informing participants about the potential for forced disclosure, thereby allowing them to meet the first Wigmore requirement.

**Conclusion**

Despite the best efforts of researchers and REBs, it will always be possible for a researcher to find herself in a conflict of duties between protecting

\textsuperscript{213} M (A) v Ryan, \textit{supra} note 63 at para 24.

\textsuperscript{214} Jackson & MacCrimmon, \textit{supra} note 44 at 121.

\textsuperscript{215} \textit{TCPS2 2014}, \textit{supra} note 2 at 60.

\textsuperscript{216} Panel on Research Ethics, “Privacy and Confidentiality”, \textit{supra} note 25, s 2(E).
confidentiality and complying with the law. No research protocol or ethics policy can anticipate all eventualities and thus researchers are not entitled to forgo warning participants of the possibility of compelled disclosure on the assumption that the data will be Wigmorized. Adopting a disposition to disobey a lawful judicial order, however, does not, in our view, constitute an ethically defensible research practice. Therefore, we recommend, contra Palys and Lowman, that researchers adopt a kind of “law-of-the-land” approach, insofar as researchers are obligated to warn participants about the possibility of forced disclosure of their sensitive, identifiable data. On the other hand, we agree with Palys and Lowman that striving to satisfy the Wigmore criteria is the best way to protect the confidentiality of research data. A warning about forced disclosure, though, will not necessarily undermine the Wigmorizing of research data.

Palys and Lowman worry that adopting “law-of-the-land” approach might serve to suppress or discourage some kinds of research. However, in order to achieve genuine informed consent, those adopting an “ethics-first” approach are obligated to inform participants of the possibility of compelled disclosure, as well as of the fact that no promise to defy compelled disclosure is legally enforceable.

---

217 Palys & Lowman, Protecting Research Confidentiality, supra note 10 at 103, 290. For this reason, Palys and Lowman have also advocated that legislatures in Canada should enact research shield legislation, similar to the statutory confidentiality certificates available in the US (ibid at 366). While a discussion and analysis of US confidentiality certificates is beyond the scope of this paper, we endorse the call for further investigation and engagement in the issue of enacting similar legislation in Canada, particularly given the uncertainties involved in attempting to Wigmorize research data.
LET THY CONSCIENCE BE THY GUIDE (BUT NOT MY GUIDE): PHYSICIANS AND THE DUTY TO REFER

Daphne Gilbert*

Since the Supreme Court of Canada struck down the ban on providing and obtaining abortions in its seminal decision *R v Morgentaler*, abortions have been a legal medical service in Canada. Accessing abortion (and contraception) remains a challenge for millions of women in Canada as the service is unevenly provided and funded. This article considers a recent challenge launched by physicians and physician advocacy groups in Ontario to policy updates by the provincial College of Physicians and Surgeons, the regulatory authority. The amended Policy on Professional Obligations and Human Rights clarified the requirements for effective referrals and the provision of urgent care in the context of religious or conscience-based objections by physicians. Those challenging the Policy argue it violates their Charter-protected rights to freedom of religion, freedom of conscience, and equality. This article assesses both sides of the legal battle:

*Associate Professor of Law, University of Ottawa Faculty of Law; Member, Centre for Health Law Policy and Ethics. I am grateful to Diana Majury and Martha Jackman who each read drafts of this paper and offered valuable suggestions. I appreciated the insight of Colleen Flood on key aspects. I am thankful to Elizabeth Sheehy for suggesting I join her at a Women’s Writing Retreat in May 2015 where this paper was born. I am grateful to the participants at that Retreat for early encouragement, and to the University of Ottawa’s Centre for Academic Leadership for sponsoring it.

© Daphne Gilbert 2017


a woman’s rights under the *Canadian Charter of Rights and Freedoms* to reproductive autonomy and a physician’s right to shape care in line with his or her beliefs. It assesses the Charter’s application to the delivery and accessibility of abortion services and contraception in Canada. This article argues that, after years of protracted debate, courts should uphold the Policy as being a strong and balanced statement on the need to protect access to reproductive services that are legal and medically necessary abortion.
INTRODUCTION

I. THE POLICY AND THE LEGAL CHALLENGE

II. THE NON-APPLICABILITY OF THE CHARTER (OR “DEFENSIVE” POSITION)
   A. Does the Charter apply to physicians?
   B. The constitutional rights of patients
      1. Section 15
      2. Section 7
      3. Section 2(a) freedom of conscience
   C. Conclusion on the negative rights or “defensive” Charter arguments

III. THE POSITIVE RIGHTS CLAIMS OR “OFFENSIVE” CHARTER ARGUMENTS
   A. Conscience exemptions in health care
      1. The bioethical dimensions to religion and conscience
      2. The moral argument for referral
   B. The Applicants’ Charter claims: The constitutional rights of physicians
      1. Section 2(a) freedom of religion
      2. Section 2(a) freedom of conscience
      3. Section 15
      4. Section 1

CONCLUSION
INTRODUCTION

There is a new weapon in the decades-long battle to limit women’s reproductive rights. In 2015, a group of physicians initiated a court challenge to a regulatory requirement which obliges them to offer effective referrals in non-emergencies and provide emergency services, despite any religious or conscience objections they might have.¹ This group of physicians (and their advocacy organizations) argue that their rights to freedom of religion, freedom of conscience, and equality under the *Canadian Charter of Rights and Freedoms (Charter)*² supersede any professional obligations they might otherwise have in the care of patients. I think this is a dangerous new offensive in the so-called “abortion wars” and one that requires a fierce response from the pro-choice movement. Physicians are the gatekeepers to abortion and often contraception. Abortion, in particular, is a service in peril in Canada, with a dearth of providers and a lack of government leadership and support in ensuring equitable access for all women in Canada. This article considers the legal challenge as framed by the plaintiff doctors. I argue that the *Charter* requires the regulatory authority to balance the rights of physicians against the rights of patients. In the contest between a physician’s right to practice a desired choice of specialty and a woman’s right to bodily integrity and autonomy in decision making, the balance lies clearly with the woman/patient.

The College of Physicians and Surgeons of Ontario (College) is the regulatory authority for medical professionals in Ontario. All doctors practicing in Ontario must be members of the College.³ The College operates under a statutory regime which requires it to register physicians, conduct ongoing education and quality assurance, investigate complaints, and mete out discipline where necessary.⁴ As part of its mandate to educate and regulate physicians, the College publishes policy statements with this goal:

---

¹ *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, Ottawa, 15-63717 (Ont Sup Ct J) [Notice of Application].

² Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

³ See College of Physicians and Surgeons of Ontario [College], “About the College”, online: <www.cpso.on.ca/About-Us>.

Policies provide specific guidance to physicians. The College develops policy to address issues that have broad application to either physicians or the public, to respond to an emerging or existing problem, and to fulfill our regulatory or public interest role.5

This article examines a recent amendment to one of the College’s key policy statements: “Professional Obligations and Human Rights” (Policy).6 In March 2015, after years of uncertainty and controversy and months of public and physician consultation, the College updated this Policy, focusing in particular on this aspect: “The policy … sets out the College’s expectations for physicians who limit the health services they provide due to clinical competence or because of their personal values and beliefs.”7

Shortly after the Policy was updated and passed by the College’s Council (its governance body), a legal challenge to overturn it was launched by a group of physicians and three physician advocacy bodies.8 The Applicants challenged the legality of two updated clauses in the Policy: the requirement that physicians make an “effective referral” when their conscience or religious beliefs prevent them from providing a service; and a requirement that physicians perform a service in urgent circumstances, even where their conscience or religious beliefs stand in opposition.9 The legal challenge has

---

5 “Policies and Publications”, online: <www.cpso.on.ca/Policies-Publications>.
6 “Policy Statement #2-15: Professional Obligations and Human Rights” (March 2015), online: <www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights.pdf?ext=.pdf> [Policy 2-15].
7 Ibid at 1.
8 Notice of Application, supra note 1.
9 Policy 2-15, supra note 6 at 9–10. It is beyond the scope of this article to engage in a full comparative review, but in my opinion, Ontario’s new policy represents a robust protection for both conscientious and religious objectors and patients seeking care. Because health care is constitutionally within the domain of provinces, there is a patchwork of approaches to the issue of conscientious and religious objections by physicians. So, for example, there are no policies on this issue in Nova Scotia, Newfoundland, and Manitoba. In Alberta, the applicable policy states:

When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical
different facets. My focus is on the Charter challenge, which I will detail below.\textsuperscript{10} The Applicants make two different Charter arguments. One aspect care is offered timely access to another physician or resource that will provide accurate information about all available medical options (College of Physicians & Surgeons of Alberta, “Standard of Practice: Moral or Religious Beliefs Affecting Medical Care” (1 January 2010), online: <www.cpsa.ca/wp-content/uploads/2015/07/M_Moral-or-Religious-Beliefs-Affecting-Medical-Care.pdf>).

In New Brunswick, the applicable policy is based on the Alberta policy: College of Physicians and Surgeons of New Brunswick, “Guidelines: Moral Factors and Medical Care” (April 2012), online: <www.cpsnb.org/english/Guidelines/MoralFactorsandMedicalCare.htm>.

The College of Physicians and Surgeons of Saskatchewan recently released its own updated policy that requires a physician to make arrangements for patients if care cannot be provided because of a conscientious or religious objection: see “Policy: Conscientious Objection” (September 2015), online: <www cps.sk.ca/Documents/Legislation/Policies/POLICY%20-%20Conscientious%20Objection%20-%20NEW%20FORMAT.pdf>.

Finally, in British Columbia the policy states:

Physicians are not obliged to provide treatments or procedures to patients which are medically unnecessary or deemed inappropriate based on scientific evidence and their own clinical expertise.

While physicians may make a personal choice not to provide a treatment or procedure based on their values and beliefs, the College expects them to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes advising patients that other physicians may be available to see them, or suggesting that the patient visit an alternate [health care] provider. Where needed, physicians must offer assistance and must not abandon the patient (College of Physicians and Surgeons of British Columbia, “Professional Standards and Guidelines: Access to Medical Care” (November 2012), online: <www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf>).

\textsuperscript{10} In addition, the Applicants argue that the new Policy 2-15, supra note 6, is ultra vires in that the College does not have the authority to implement policies that violate the Charter. The Applicants also argue the new Policy violates the rights of the individual physicians under the Human Rights Code, RSO 1990, c H.19, though no particular section is cited. Finally, in terms of non-Charter objections, the Applicants argue that the consultation process around the changes
of their position is that the Charter does not apply to their actions.\textsuperscript{11} I call this a “defensive” Charter claim in that they argue that as physicians, they are not subject to nor bound by the Charter in their medical practice in terms of carrying out their duties as physicians. Therefore, they claim they cannot be charged with violating the Charter when their religious or conscience beliefs shape their decisions in providing care to patients. They “defend” their actions by arguing the Charter does not apply. The second argument is a positive assertion of their own rights. This affirmative Charter claim is that the new Policy clauses on effective referral and urgent care violate three of their individual Charter rights: the Section 2(a) right to freedom of conscience; the Section 2(a) right to freedom of religion; and the Section 15 right to equality (the right to equal treatment under the law without discrimination based on religion).\textsuperscript{12} I will examine both arguments in turn.

\section*{I. The Policy and the Legal Challenge}

An amended Notice of Application challenging the revised Policy was filed on 21 May 2015 by a coalition of individuals and physician advocacy organizations in \textit{The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario} (Notice of Application).\textsuperscript{13} The Applicants include:

- The Christian Medical and Dental Society of Canada (CMDS), which is described in the Notice of Application as “a national and interdenominational association of Christian doctors and dentists who strive to integrate their Christian faith with medical or dental practice.” While the CMDS’s members include Catholics, over 90\% identify as Protestant Evangelicals.

---

\textsuperscript{11} Notice of Application, \textit{supra} note 1 at 13.

\textsuperscript{12} \textit{Ibid} at 12.

\textsuperscript{13} \textit{Ibid} at 1.
• The Canadian Federation of Catholic Physicians’ Societies, described as “a national association of Catholic Physicians’ guilds, associations and societies from eleven cities across Canada, four of which are in Ontario.”

• Canadian Physicians for Life, described as a “national association of pro-life physicians, retired physicians, medical residents and students.”

• Five individual physicians.\(^{14}\)

All five of the individual physicians claim that their sincerely held religious beliefs “inform and direct [their] positions on certain procedures, pharmaceuticals and procedures which a patient may request” and that these beliefs and their consciences “prevent [them] from participating in a number of procedures or providing a number of pharmaceuticals to which [they object] on religious or moral grounds.”\(^{15}\) Together, the Applicants object to two clauses in the Policy. Their first concern is with “effective referral” obligations. The clause reads:

Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided

\(^{14}\) Ibid at 4–5. All the plaintiffs practice in Ontario. Four of the five individual plaintiffs are described as “committed Protestant Evangelical Christians”: Dr. Michelle Korvemaker, an emergency medicine, palliative care, and family physician (ibid at 5); Dr. Betty-Ann Story, a family physician (ibid at 6); Dr. Isabel Nunes, a family physician (ibid); and Dr. Donato Gugliotta, a family physician and anaesthetist (ibid at 7–8). The fifth plaintiff, Dr. Agnes Tanguay, is a family physician described as a “committed Roman Catholic.” Her claim also includes reference to a 2014 complaint filed against her for a refusal to prescribe specific pharmaceuticals or referrals for pharmaceuticals because of her conscience and sincerely held religious beliefs (ibid at 7). Dr. Tanguay has a practice at CareMedics Walk-In Clinic in Ottawa, which she runs with two other physicians. In 2014, the three sent a letter to their patients informing them that the physicians would not write prescriptions for artificial birth control because of their religious beliefs. See also Elizabeth Payne, “Debate About Doctors’ Right to Refuse Treatment for Religious Reasons Re-ignited”, Ottawa Citizen (9 February 2014), online: <www.ottawacitizen.com/news/local-news/debate-about-doctors-right-to-refuse-treatment-for-religious-reasons-re-ignited>.

\(^{15}\) Ibid at 5–8.
to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients.\textsuperscript{16}

The Applicants argue that mandating an “effective referral” forces physicians to “participate in a procedure or facilitate the administration of pharmaceuticals to which he or she objects on moral or religious grounds.”\textsuperscript{17} They allege that this forced participation is a violation of individual Charter rights to freedom of conscience and religion, or both.\textsuperscript{18}

The Applicants also object to a clause requiring physicians to provide pharmaceuticals or perform procedures to which they object on moral or religious grounds if the care if “urgent” or “otherwise necessary.”\textsuperscript{19} The clause states: “Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs.”\textsuperscript{20}

Before I turn to the substance of my argument, there are two caveats about how I have approached this claim. First, my focus in this article will be on the implication of conscientious or religious objections to caring for the reproductive capacity of women. I am interested in the impact of the physicians’ claims on the ability of women to access contraception and abortion. The legal challenge filed by these Applicants is not restricted to this issue and there is no doubt that the physicians’ arguments have a broader scope. There are those who have conscientious and religious objections to

\begin{footnotes}
\item[17] Notice of Application, \textit{supra} note 1 at 9.
\item[18] \textit{Ibid}.
\item[19] \textit{Ibid} at 10.
\item[20] \textit{Ibid} at 5.
\end{footnotes}
assisted death, supervised drug injection sites and other issues that arise in front line or primary care medicine. While my arguments may equally apply to those issues, I have focused here on women’s reproductive capacity as the most illustrative of the contested rights dilemma posed by conscientious and religious objections to care.\footnote{Bioethicists Chloë FitzGerald and Carolyn McLeod argue that in the literature on conscientious refusal of medical care, not enough attention is paid to refusals to provide abortion and contraceptive services. They conclude that overlooking the specific dynamics of women’s reproductive health:

... simply misrepresents the phenomenon of conscientious refusal in health care (at least within the U.S.), which arose in the midst of heated debate about abortion and is still embedded to some degree in this political context. Conscientious refusal is tied – in health care, not in the military – generally speaking with right-wing political agendas and opposition to them, particularly agendas that favor the traditional family and women’s place within it. Portraying the phenomenon as though it either did not have this connection or was politically neutral is misleading (“Conscientious Refusal and Access to Abortion and Contraception” in John D Arras, Elizabeth Fenton & Rebecca Kukla, eds, Routledge Companion to Bioethics (New York: Routledge, 2015) 343 at 347.).}

My second caveat: the Applicants, both as individuals and as advocacy organizations, have outlined absolute Charter entitlements. As I understand the claim, they are not offering any contingent compromises or concessions. They see the situation in absolute terms: physicians should never have to perform a course of treatment that goes against their conscience or religious beliefs, nor should they have to refer a patient to another physician who will. If the physicians’ rights are absolute, then they must be understood as potentially (perhaps even ideally) operating as a complete bar to accessing service. And for some women, that would indeed be true. In rural or remote communities, for example, other physicians may be impossible to consult. If the pregnancy is reaching a critical turning point in terms of accessing a safe abortion, if a woman desperately needs birth control because she is in an unsafe or unpredictable relationship, if a teenager had to skip school or arrange transportation and may not easily be able to do so again, if a woman is distraught and overwhelmed by an unexpected pregnancy and used up all of her emotional reserves to face one appointment, if for any reason being “resourceful” is not possible, then women will be left pregnant, or unprotected from pregnancy. My argument proceeds on the assumption that physicians with conscientious objections would assert their constitutional rights de-
spite adverse consequences for women. I do not assume that physicians with conscientious objections would either expect or hope that someone else will perform abortions or provide contraception in their place, in order to mitigate the harm to women.

II. The Non-Applicability of the Charter (or “Defensive” Position)

The individual Applicants argue that neither they, nor other physicians, are bound by or subject to the Charter. Therefore, they conclude that their refusal to participate in, or to provide certain procedures or pharmaceuticals for, an abortion or a contraceptive treatment does not amount to discrimination or otherwise violate the Charter rights of patients. In essence, they argue that since they are not subject to the Charter, they cannot be accused of violating it in how they deliver services to clients.

There are two aspects to this claim. First is the allegation that physicians are not subject to Charter obligations in performing their duties as physicians. I will explore this in greater detail. Second is the implied understanding of the Applicants that, but for the fact they are not subject to the Charter, they could indeed face Charter challenges from patients whose care was affected by a physician’s failure to comply with the Policy. In other words, I assume that underlying their argument is a concern that if the Charter applies to their decision making as physicians, it could limit their conscience claims. It is a good strategic move for the physicians to argue both aspects of their Charter claim. The applicability of the Charter to physicians is a legally unsettled question to date. The Policy itself is ambiguous on whether the Charter governs physicians in their practice. It states:

Where physicians choose to limit the health services they provide for reasons of conscience or religion, this may impede access to care in a manner that violates patient rights under the Charter and [Ontario Human Rights] Code. The courts have

---

22 It is my position that women will suffer adverse consequences if front line emergency or family physicians are unable to provide information on the full set of options for contraception or pregnancy management. Any physician-imposed limit on women’s legal choices constitutes an adverse consequence in my view.

23 Notice of Application, supra note 1 at 13.
determined that there is no hierarchy of rights; all rights are of equal importance.  

This statement recognizes that patients’ Charter rights protect the kind of care they receive, which would necessarily suggest that physicians are subject to the Charter in the delivery of that care. Surprisingly, this remains an unresolved legal question.

A. Does the Charter apply to physicians?

While the Notice of Application does not state the basis for the physicians’ assertion that they are not bound by the Charter in the performance of their duties, presumably they see themselves as arm’s-length contractors to the State and not salaried employees. In this way, they distinguish themselves from other public services like the police, who are paid directly by government (provincial, federal, or municipal depending on the force). On the one hand, it may make little practical difference whether physicians are subject to the Charter. When a doctor behaves in a discriminatory, harassing, or negligent way, the usual course of action for a patient is to pursue disciplinary proceedings under the relevant regulatory body or to launch civil proceedings. Patients may also make human rights complaints that

24 Policy 2-15, supra note 6 at 4.

25 The complaint process in Ontario is outlined on the website of the College, “Complaints Process”, online: <www.cpso.on.ca/Policies-Publications/Complaints/The-Complaints-Process> (there is a graduated list of possible outcomes, from dismissal of the complaint to a referral of the complaint to the Discipline Committee).

26 See e.g. Norberg v Wynrib, [1992] 2 SCR 226, 92 DLR (4th) 449 [Norberg cited to SCR]. In Norberg, Justice McLachlin (as she then was) analyzed the relationship between doctor and patient as a fiduciary relationship and concluded:

I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires (ibid at 272).
come with a more direct set of remedial options. A patient’s Charter challenge alleging, for example, discrimination by a physician under Section 15, would result in a hollow victory for the patient-claimant. The court could issue a declaration that a patient’s Charter rights had been violated. Some small monetary damages could be assessed, but would likely amount to less than what would be available in tort or under the human rights regime. Practically speaking, a wronged patient is unlikely to pursue a Charter case.

This further supports the existence, at least in a civil litigation context, of a physician’s obligations of both full disclosure of their own limitations (both in skill and in conscience) and of effective referral to a colleague who can exercise fiduciary power in the woman’s best interest.

See e.g. Human Rights Code, supra note 10. Section 1 mandates equal treatment in the delivery of services without discrimination based on sex (in addition to other grounds). Services include hospital and health care services. Relevant to our context is subsection 10(2): “The right to equal treatment without discrimination because of sex includes the right to equal treatment without discrimination because a woman is or may become pregnant.” Subsubsection 45.2(1) sets out the remedial powers of the Human Rights Tribunal and includes the payment of monetary compensation, restitution, or any other remedy the Tribunal deems necessary.

Section 24(1) is the Charter’s very broad remedial provision: “Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances” (supra note 2). The Court has been unremarkable in its remedies when unconstitutional government action is involved: see e.g. Little Sisters Book and Art Emporium v Canada (Minister of Justice), 2000 SCC 69, [2000] 2 SCR 1120 (see especially Iacobucci J, dissenting at paras 258–61, on the inadequacy of declaratory judgments in some cases).

See Vancouver (City) v Ward, 2010 SCC 27, [2010] 2 SCR 28 (the leading Supreme Court of Canada decision on monetary damages for Charter breaches).

See Doe v Metropolitan Toronto (Municipality) Commissioners of Police (1998), 39 OR (3d) 487, 160 DLR (4th) 697, (Ont Ct J (Gen Div)), for an example of a successful Section 15 suit by a claimant against the Metropolitan Toronto Police Force on the ground of sex discrimination for a failure to warn neighbourhood women of a serial rapist in the area. The claimant received a declaration that her rights were violated and damages of almost $200,000 for both tort negligence and a Charter breach were awarded. The court did not award a specific amount for the Charter breach (the remedies for tort and Char-
On the other hand, it is important to resolve the question of whether physicians are government actors for the purpose of the Charter, and not only because of the esoteric legal point. In their Notice of Application, the individual doctors claim to be protected in their conscientious objection by the Charter. In their narrative, their rights are absolute, without any countervailing Charter claims or rights. The Applicants therefore set out their claim without any need to allow for a balancing of Charter rights, or for the recognition of competing interests. Even if patients would be unlikely to pursue Charter actions against physicians, the legal reality that patients have Charter rights as against doctors who behave in Charter-violating ways is important to an assessment of the doctors’ own rights as against those same patients.

There is no case law that conclusively establishes whether the Charter applies to health care providers outside the hospital context. Eldridge v British Columbia (AG), a 1997 Supreme Court decision, remains the leading authority on the Charter’s applicability to the delivery of health care. In Eldridge, the claimants argued a violation of Section 15(1) of the Charter for the government’s failure to provide sign language interpretation in British Columbia hospitals. The claim was framed as an “adverse effects” claim, as the claimants argued that they had a right to effective communication with health care providers, a right that was compromised by their disability (deafness). The government was not charged with being directly discriminatory; rather, the claimants argued that the government failed to account for the needs of the deaf community by structuring care on a hearing model, and that this failure resulted in adverse consequences to the deaf. Justice La Forest wrote a unanimous decision for the Court upholding the claim. He acknowledged that hospitals, in the daily management of their affairs, act as private entities, and not as government ones, pursuant to Section 32(1) of the Charter. However, in implementing the government’s pro-

31 Eldridge v British Columbia (AG), [1997] 3 SCR 624, 151 DLR (4th) 577 [Eldridge cited to SCR].

32 Ibid at para 60.

33 Ibid at paras 46–48. Section 32(1) of the Charter, supra note 2, states:

This Charter applies

a) to the Parliament and government of Canada in respect of all
gram of publicly-funded medical care to Canadians, hospitals’ actions, in how they deliver that care, could be the subject of Charter scrutiny. On this point, Justice La Forest distinguished the internal management of hospital operations (mandatory retirement policies, for example) from the delivery of patient care. He noted that the decisions of Boards of Directors, for example as considered in Stoffman v Vancouver General Hospital, were immune from Charter challenge when making decisions that do not implicate government policy. He concludes:

The structure of the Hospital Insurance Act reveals, therefore, that in providing medically necessary services, hospitals carry out a specific governmental objective. The Act is not, as the respondents contend, simply a mechanism to prevent hospitals from charging for their services. Rather, it provides for the delivery of a comprehensive social program. Hospitals are merely the vehicles the legislature has chosen to deliver this program. It is true that hospitals existed long before the statute, and have historically provided a full range of medical services. In recent decades, however, health care, including that generally provided by hospitals, has become a keystone tenet of governmental policy. The interlocking federal-provincial medicare system I have described entitles all Canadians to essential medical services without charge. Although this system has retained some of the trappings of the private insurance model from which it derived, it has come to resemble more closely a government service than an insurance scheme...

This means, while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act. The Legislature,

matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

Elridge, supra note 31 at 663–64; Stoffman v Vancouver General Hospital, [1990] 3 SCR 483, 76 DLR (4th) 700 concerned a challenge to mandatory retirement rules in the Board’s granting of hospital privileges.

Eldridge, supra note 31 at 665.
upon defining its objective as guaranteeing access to a range of medical services, cannot evade its obligations under [Section] 15(1) of the Charter to provide those services without discrimination by appointing hospitals to carry out that objective. In so far as they do so, hospitals must conform with the Charter.36

Following Eldridge, health law scholar Martha Jackman concluded:

The difficult question left unresolved by the Eldridge case is the application of the Charter to the actions of non-employee health care providers working in hospitals, as well as independent health care providers delivering health care services in other settings, most notably physicians. Justice [La Forest]'s analysis in Eldridge would appear to be equally applicable to individual as to institutional care givers. For example, while most physicians in Canada are paid on a fee-for-service basis, the insurance model for delivery of medical care in Canada is largely a historical anomaly. Physician services are funded

---

36 Ibid at 665. In Eldridge, the claimants were successful in arguing that the lack of sign language interpretation was discriminatory because of the historically disadvantaged condition of individuals with disabilities and society's structuring of our institutions as premised on an able-bodied ability to hear (ibid at para 56). The issue of the Charter's applicability to hospitals in the delivery of care will have significant consequences in upcoming debates over physician-assisted death in Canada. Physician-assisted death raises many conscience claim arguments similar to those articulated here by physicians (and will be the subject of further work by this author). More dramatically, however, entire religiously-based hospitals have asserted a conscience right not to perform that service as constitutionally mandated in Canada by the Supreme Court's decision in Carter v Canada (AG), 2015 SCC 5, [2015] 1 SCR 331 [Carter]. In Ottawa, for example, the Bruyère, a publicly funded Catholic health care provider, has formally announced that it will not provide physician-assisted death, nor refer patients for that service. According to CBC News, in a memorandum dated 20 January 2016, the Centre's director Daniel Levac stated that “the organization is ‘obligated’ to stand behind its sponsor, the Catholic Health Sponsors of Ontario.” The memorandum referred to a December 2015 statement by the Catholic Health Sponsors of Ontario that it “would not provide physician-assisted death in its institutions and would not ‘directly or explicitly’ refer a patient to get the medical procedure elsewhere.” (Chloé Fedio, “Bruyère Won’t Offer Physician-assisted Death: Memo”, CBC News (28 February 2016), online: <www.cbc.ca/news/canada/ottawa/bruyere-doctor-assisted-death-1.3466192>.)
almost entirely through provincial health and hospital insurance regimes, and medicare remains one of the most [important] social policies and programs provided by government.37

Professor Jackman therefore argues that Eldridge likely means physicians are subject to the Charter in delivering services, even when they are not employees but independent contractors. She suggests:

Like hospitals, physicians and other publicly funded health care providers can readily be characterized as acting “as agents for government in providing the specific medical services set out” in provincial health insurance legislation, under the general framework of the Canada Health Act.38

Some of the confusion around the applicability of the Charter to physicians may stem from a Supreme Court decision in the criminal law and evidence context, R v Dersch.39 The decision is quite brief and focused on the provision of evidence to the police for use in a criminal law investigation. In Dersch, the Court considered whether it was an unreasonable search and seizure (and thus a violation of Section 8 of the Charter) for a blood sample taken by a physician for medical purposes to also be used for evidentiary purposes in establishing a blood-alcohol level to support criminal charges. The Court held that the doctors were not acting as agents for the State when they collected the blood sample in the provision of emergency health services, and therefore the Charter did not apply to the “seizure.”40 However, in turning over the results of the blood test to the police, the doctors’ conduct was wrong. The accused had a reasonable expectation of privacy in his medical tests and the doctors’ violated his right to confidentiality.41 The police acted in violation of the Charter in using information improperly obtained. The police, in other words, committed the Charter violation of an

38 Ibid, citing Eldridge, supra note 31 at 665.
40 Ibid at 777.
41 Ibid.
unreasonable seizure by making use of improperly obtained blood results for criminal purposes.\footnote{Ibid at 777–78.}

In my view the Court’s reasoning in the specific factual context of this case should not be extrapolated to physicians acting as physicians in the performance of their own duties. I think that this decision must be reserved to its specific context. The Court did not say that physicians are not bound by the \textit{Charter} in the performance of their duties as physicians. The doctors erred in this case by breaching patient-physician confidentiality in releasing the results of the blood tests to police. The Court makes no comment on the doctors’ own care of the patient and whether the \textit{Charter} applied to how that care was carried out. It instead makes a subtler point about the role of the doctor vis-à-vis investigating police officers. The Court’s point was that the doctors were not delegated investigative criminal law authority by the police when the blood sample was taken. They were not acting as delegated police agents of the State and therefore did not engage in a \textit{Charter} violating “seizure” in taking the blood. I do not interpret \textit{Dersch} as applying to the entirely different question about whether the \textit{Charter} applies to physicians in the course of their ordinary role.

Since \textit{Eldridge}, the Supreme Court’s most significant health care decision is \textit{Chaoulli v Québec (AG)}.\footnote{2005 SCC 35, [2005] 1 SCR 791 [\textit{Chaoulli}].} It considered whether provincial legislation that prohibited private medical insurance violated either the \textit{Charter} or Québec’s \textit{Charter of Human Rights and Freedoms} (Québec \textit{Charter}) when the claimants were subject to long wait times for surgery in the publicly-funded medical system. A majority of the Court held that the prohibition violated the Québec \textit{Charter}. Chief Justice McLachlin wrote a concurring set of reasons finding a violation of the \textit{Charter}. She argued: “The \textit{Charter} does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the \textit{Charter}.”\footnote{Ibid at para 104. Justice Deschamps, who writes the majority opinion, does not consider the \textit{Charter} because in her view, the violation of the Québec \textit{Charter of Human Rights and Freedoms} is sufficient to allow the appeal (\textit{ibid} at para 15). Chief Justice McLachlin writes separately (with two other judges) because she thinks it important to address the \textit{Charter} argument. Her decision is a persuasive authority on these issues.} She cited section 3 of the \textit{Canada Health Act}, which reads:

\begin{itemize}
  \item \textbf{Ibid} at 777–78.
  \item 2005 SCC 35, [2005] 1 SCR 791 [\textit{Chaoulli}].
  \item \textit{Ibid} at para 104. Justice Deschamps, who writes the majority opinion, does not consider the \textit{Charter} because in her view, the violation of the Québec \textit{Charter of Human Rights and Freedoms} is sufficient to allow the appeal (\textit{ibid} at para 15). Chief Justice McLachlin writes separately (with two other judges) because she thinks it important to address the \textit{Charter} argument. Her decision is a persuasive authority on these issues.
\end{itemize}
It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.\textsuperscript{45}

In her reasons, she adds emphasis to the phrase “facilitate reasonable access” and concludes that “[b]y imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of [Section] 7 of the Charter.”\textsuperscript{46} This reasoning is relevant to the question of whether the \textit{Charter} applies to individual doctors. In creating a monopoly over the delivery of health care, the federal government, in concert with the provincial governments, guarantees “reasonable access to health services.” In \textit{Chaoulli}, a lack of access to health care was analyzed as a structural problem of the health care system as a whole. In the case of individual physicians, the problem of access to health care is also structural: it stems from the effect of physician self-regulation combined with the monopoly on who can deliver services and under what circumstances. To paraphrase Chief Justice McLachlin’s words in this context, the “scheme” that the provinces have established to deliver publicly-funded health care to Canadians through regulated family physicians must be subject to the \textit{Charter} even if there is no free-standing constitutional right to health care. A failure to provide reasonable access to legal and publicly-funded medical services triggers \textit{Charter} scrutiny. As a self-regulated monopoly, physicians who fail to provide all legal and publicly-funded health services (those within their competence and specialty), should be subject to \textit{Charter} scrutiny. This passage outlines Chief Justice McLachlin’s view of the issues in \textit{Chaoulli} as compared to those raised in \textit{R v Morgentaler}\textsuperscript{47}:

\begin{quote}
In this appeal, delays in treatment giving rise to psychological and physical suffering engage the [Section] 7 protection of security of the person just as they did in \textit{Morgentaler}. In \textit{Morgentaler}, as in this case, the problem arises from a legislative scheme that offers health services. In \textit{Morgentaler}, as in this case, the legislative scheme denies people the right to access alternative health care. \textit{(That the sanction in Morgentaler was}
\end{quote}

\textsuperscript{45} \textit{Canada Health Act}, RSC 1985, c C-6, s 3.

\textsuperscript{46} \textit{Chaoulli, supra} note 43 at para 105.

\textsuperscript{47} [1988] 1 SCR 30, 44 DLR (4th) 385 [\textit{Morgentaler} cited to SCR].
criminal prosecution while the sanction here is administrative prohibition and penalties is irrelevant. The important point is that in both cases, care outside the legislatively provided system is effectively prohibited.) In Morgentaler the result of the monopolistic scheme was delay in treatment with attendant physical risk and psychological suffering. In Morgentaler, as here, people in urgent need of care face the same prospect: unless they fall within the wealthy few who can pay for private care, typically outside the country, they have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails. As in Morgentaler, the result is interference with security of the person under [Section] 7 of the Charter.48

Of significance in this comparison is her bracketed observation that it matters not that one case concerned criminal law while another is set in the administrative context. She emphasizes that what matters is the legislated nature of the health care context.

In Morgentaler, the Court struck down criminal law regulation of abortion as violating a woman’s Section 7 rights to security of the person. There was no question the Charter applied to a Criminal Code provision. In Chaoulli, Chief Justice McLachlin is clear that the applicability of the Charter is not reserved for criminal law clashes with health care. A similar point seems to be made in the Court’s recent decision in Carter v Canada (AG) (Carter) to strike down a criminal law ban on physician-assisted dying.49 As in Morgentaler, there is no question the Charter applies to the Criminal Code, but the Court also remarks:

In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians’ colleges, Parliament, and the provincial legislatures. However, we note – as did [Justice] Beetz ... in addressing the topic of physician participation in abortion in Morgentaler – that a physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-

48 Chaoulli, supra note 43 at para 119 [emphasis added].

49 Carter, supra note 36.
empt the legislative and regulatory response to this judgment. 

Rather, we underline that the Charter rights of patients and physicians will need to be reconciled.\textsuperscript{50}

Taken together, Chaoulli and Carter recognize the broad applicability of the Charter to contexts outside the criminal law realm. This passage from Carter also lends support to the notion that patients do have Charter rights as against their physicians in terms of legal and funded care and that physicians’ own Charter rights will have to be reconciled with those of his or her patients.

The case law is sparse in this area, but one interesting civil action was in part premised on the argument that the Charter applied to physicians in delivering services. In a torts claim for negligence against a surgeon, the plaintiffs filed a “Notice Under the Constitutional Questions Act” (Notice) which assumed as one of its “facts giving rise to the constitutional questions” that, “[t]he integrated federal-provincial medicare system entitles all Canadians to access essential medical care without discrimination.”\textsuperscript{51} The Notice also claims: “Hospitals and doctors are agents of government when they are providing medically necessary services. In so doing, hospitals and doctors must conform to the Canadian Charter of Rights and Freedoms.”\textsuperscript{52} In this case, Hobbs v Robertson, the plaintiff family members argued that their deceased wife and mother was forced to sign a liability release form for her refusal to accept a blood transfusion. The deceased was a Jehovah’s Witness with a sincere religious belief that she could not accept a blood transfusion. She needed a hysterectomy, and when she arrived at the hospital to be admitted, she was presented with a liability release form. She died in surgery at the admitted negligence of her surgeon. Her family sued in negligence but the doctor argued the release was a waiver of liability.\textsuperscript{53} The Notice filed in the litigation argued that requiring a patient to contract out

\textsuperscript{50} Ibid at para 132 [emphasis added].

\textsuperscript{51} Hobbs v Robertson, 2006 BCCA 65, 265 DLR (4th) 537, Schedule B, Notice Under the Constitutional Questions Act of the Plaintiffs at para 2 [Hobbs, Schedule B]. The litigation history in this case is a tortured one, with the case being sent back for a new trial some ten years after the patient’s death. I can find no record of the second trial, nor can I find any indication of a response to Hobbs, Schedule B. I assume the case was settled out of court.

\textsuperscript{52} Ibid.

\textsuperscript{53} Ibid at paras 1–3.
of liability for negligence in order to access government-funded health care infringed her Sections 2(a), 7, and 15 rights.\textsuperscript{54}

To conclude on the applicability of the \textit{Charter} to the work of physicians in delivering services to patients, given a monopoly in delivering a government-funded public service (insured medical care), one consequence of the privilege of self-regulation should be compliance with the \textit{Charter}. The \textit{Charter} might conceivably apply to require non-discriminatory care under Section 15 or to obligations around securing informed consent, so as not to violate a patient’s Section 7 right to security of the person. Section 7 might also be implicated if a prescribed course of treatment (or a refusal to provide treatment) threatens the life or security of the person of a patient. Section 2(a) conscience rights might also be implicated when a patient is denied the ability to make treatment decisions according to her own conscience, when the physician’s conscience operates as an override or veto. In the Part to follow, I briefly consider the constitutional issues for women in a physician’s refusal to provide or refer for contraception and abortion. If the \textit{Charter} applies to physicians in their delivery of care, these are some of the claims that women might bring if the Policy on effective referral or urgent care is not followed.

\textbf{B. The constitutional rights of patients}

\textbf{1. Section 15}

Section 15(1) of the \textit{Charter} states:

\begin{quote}
Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.\textsuperscript{55}
\end{quote}

Section 15 could be invoked by a client who is refused service on the basis of any of the enumerated or analogous grounds (including the analogous ground of sexual orientation). In the context of reproductive health choices

\textsuperscript{54} \textit{Ibid} at paras 4–5.

\textsuperscript{55} \textit{Supra} note 2.
for women, the target of many conscience- and religion-based physician objections, sex discrimination claims could be leveled for a failure to provide contraceptives, perform an abortion, or fulfill the Policy’s requirement for an “effective referral” to obtain those services. Obviously a denial of abortion services is a sex discrimination issue for women since only women obtain them. Similarly, prescriptions for birth control are only available for women.

A Section 15 sex discrimination claim against doctors would require a woman to show a distinction in treatment based on an enumerated or analogous ground and to show that the treatment exacerbated or perpetuated disadvantage. Step one is fulfilled by a woman client showing that she was unable to get the complete range of necessary (and legal and funded) health services available to her – this is the distinction in treatment from a man who receives all necessary health services, and this difference in treatment is based on her sex (which it is if for example, access to abortion is the issue). Step two is fulfilled when the notions of prejudice and stereotype are explored in a reproductive context. A denial of reproductive health services furthers the stereotype that the appropriate role for women is as grateful mothers who welcome their fecundity no matter the circumstances. Women can also argue prejudice from the resulting loss of earning capacity, lack of freedom of choice in life options, child care burdens and expenses, and other concerns which can follow a pregnancy carried to term.

It is well-established that despite efforts to improve access and funding for child care and some changes to gendered parenting assumptions around care, women still bear the primary economic and social costs of child-bearing and child-rearing. Denying women reproductive control is not only about the nine months of an unwanted pregnancy, but the potential imposition of a lifetime of child care obligations. In her powerful dissent in a recent abortion decision by the Supreme Court of the United States, Gonzales v Carhart, Justice Ginsburg set out a sex discrimination argument to restrictions on accessing abortion. Justice Ginsburg argued:

Women, it is now acknowledged, have the talent, capacity, and right “to participate equally in the economic and social life of the Nation.” Their ability to realize their full potential … is intimately connected to “their ability to con-

---

56 See below for a more fulsome discussion on the steps of a Section 15 challenge. This two-part test comes from the Supreme Court’s decision in R v Kapp, 2008 SCC 41 at para 25, [2008] 2 SCR 483 [Kapp].
trol their reproductive lives.” Thus, legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature.57

In Morgentaler, Justice Wilson framed her assessment of the liberty interest under Section 7 as including equality rights for women:

The more recent struggle for women’s rights has been a struggle to eliminate discrimination, to achieve a place for women in a man’s world, to develop a set of legislative reforms in order to place women in the same position as men … It has not been a struggle to define the rights of women in relation to their special place in the societal structure and in relation to the biological distinction between the two sexes. Thus, women’s needs and aspirations are only now being translated into protected rights. The right to reproduce or not to reproduce which is in issue in this case is one such right and is prop-

57 Gonzales v Carhart, 550 US 124 (2007) at 171, 127 S Ct 1610 [Gonzales] [references omitted], citing Planned Parenthood of Southeastern Pa v Casey, 505 US 833 (1992) at 856, 112 S Ct 2791 [Casey]. Ginsburg also notes at footnote 3 of her opinion in Gonzales:

Adolescents and indigent women, research suggests, are more likely than other women to have difficulty obtaining an abortion during the first trimester of pregnancy. Minors may be unaware they are pregnant until relatively late in pregnancy, while poor women’s financial constraints are an obstacle to timely receipt of services (at 173).

This is an important argument in our context because these two groups are also those who may have fewer emotional, financial, or supportive resources to obtain information about their options in the face of a refusal to provide urgent care or refer the patient to a physician who can provide this care. The majority decision in Gonzales was written by Justice Kennedy. At issue was the “Partial-Birth Abortion Ban Act,” Congressional legislation that banned a certain kind of abortion procedure (ibid at 132). The majority of the Court upheld the legislation as not constituting an “undue burden” on women in accessing abortion services (ibid at 146–47). “Undue burden” is the American term of art for the constitutional requirement that any laws regulating abortion before fetal viability not act as a significant obstacle to women in accessing the service.
erly perceived as an integral part of modern woman’s struggle to assert her dignity and worth as a human being.\textsuperscript{58}

Justice Ginsburg also condemns the judicial imposition of a moral code in assessing laws that restrict access to the fundamental right to abortion. She invokes the Court’s seminal abortion decision in \textit{Planned Parenthood of Southeastern Pa v Casey} and concludes:

Notably, the [moral] concerns expressed are untethered to any ground genuinely serving the Government’s interest in preserving life. By allowing such concerns to carry the day and case, overriding fundamental rights, the Court dishonors our precedent. See, e.g., \textit{Casey} (“Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code.”)\textsuperscript{59}

This is helpful in our context of considering a woman’s claim that she is owed non-discriminatory care by her physician. If judges cannot impose their moral code in assessing laws that compromise a woman’s fundamental rights, physicians subject to the \textit{Charter} should not be able to do so either. If they do, this conscience override exacerbates the disadvantage experienced by women in the full realization of their autonomy and dignity. This constitutes a violation of equality rights under Section 15.

\textbf{2. Section 7}

Section 7 claims require a claimant to show that one of the protected interests – life, liberty, or security of the person – has been compromised by state action and that the violation is not in accordance with the principles of

\textsuperscript{58} Morgentaler, supra note 47 at 172 [emphasis in original].

\textsuperscript{59} Gonzales, supra note 57 at 15 [reference omitted]. The decision to which Justice Ginsburg refers, \textit{Casey, supra} note 57 at 850, is the leading Supreme Court precedent on abortion regulation in the United States. It affirmed that the Constitution protects a fundamental right to accessing abortion for women as both a liberty and privacy interest. In short, before viability, states can legislate to make abortion safer for women as long as they do not place an “undue burden” on access. After viability, states can legislate to protect the potential life of the fetus even to the point of banning abortion, as long as an exception is made to protect the life of the pregnant woman.
fundamental justice. The Supreme Court has already held that the inability to obtain an abortion constitutes a violation of a woman’s security of the person interest. The lack of access potentially endangers her life but it also implicates her psychological integrity by taking a life-altering decision out of her hands. Physicians who impeded access to abortion services (or birth control) could conceivably cause high levels of psychological stress in women, stress that is State-imposed if the physician is operating as a state agent in delivering care. The operative principle of fundamental justice is gross disproportionality. In Carter, the Court set out the meaning of this principle of fundamental justice: “The inquiry into gross disproportionality compares the law’s purpose, ‘taken at face value’, with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law.” It is understood that physicians have consciences and may bring moral judgment to bear in their work. The Policy offers protections for conscience-based objections by allowing physicians to opt out (unless the situation is an emergency). Physicians are normally required not to discriminate in providing services, but the Policy contemplates circumstances where discrimination is permitted. When, however, the denial of service impacts on the security of person of a patient, a physician’s conscience-motivated conduct in denying medical services is grossly disproportionate. Allowing a physician’s conscience to trump the security of the person of a patient operates entirely to the benefit of the physician to the great detriment of the patient. This is especially evident in a denial of effective referral where the physician is not even required to provide the service, and yet the patient is left without any course of treatment.

60 Morgentaler, supra note 47 represents the Canadian Supreme Court’s only substantive treatment of an abortion law. It was narrowly framed in a legal sense as a challenge to the existing ban on abortion and in particular, the exceptions set out in the Criminal Code. The Court did not consider whether any criminal regulation would be unconstitutional, but many scholars interpret the decision as protective of a woman’s constitutional right to access abortion. While only the challenged regime was deemed unconstitutional, the Court’s reasoning would make it impossible for a government to completely ban abortion (for example). The language used by both Justice Dickson (see e.g. ibid at 56) and Justice Wilson (see e.g. ibid at 171–74) suggests that a woman’s security of the person and liberty rights require some access to abortion services.

61 See discussion above on whether the Charter applies to physicians in the performance of their duties.

62 Carter, supra note 36 at para 89.
3. Section 2(a) freedom of conscience

There is little jurisprudence on the meaning and content of a right to freedom of conscience, though it is clear that the Supreme Court does see it as a freedom with meaning distinct from freedom of religion. The leading Supreme Court decision remains Justice Bertha Wilson’s concurring set of reasons in *Morgentaler.* In *Morgentaler,* the Court struck down the criminal ban on abortion as the process for obtaining an exemption to prosecution was arbitrary, inconsistently applied across the country and unequally available to all Canadian women. The majority decision, by Chief Justice Dickson, rested on Section 7 of the *Charter* and described the main problem as a violation of a woman’s security of the person. Justice Wilson’s concurring reasons went much further:

This decision [to procure an abortion] is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.

While she agreed with the majority that the criminal provision violated a woman’s Section 7 rights, she framed her analysis of the principles of fundamental justice as being shaped by a woman’s freedom of conscience. She concluded:

Accordingly, for the state to take sides on the issue of abortion, as it does in the impugned legislation by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one

---

63 For an excellent overview of the history and meaning of Section 2(a) freedom of conscience, see Richard A Haigh, *A Burl on the Living Tree: Freedom of Conscience in Section 2(a) of the Canadian Charter of Rights and Freedoms* (SJD Thesis, University of Toronto Faculty of Law, 2012).

64 *Morgentaler,* supra note 47 at 56–63.

65 *Ibid* at 171.
conscientiously-held view at the expense of another. It is to deny freedom of conscience to some, to treat them as means to an end, to deprive them, as Professor MacCormick puts it, of their “essential humanity”. Can this comport with fundamental justice? Was [Justice] Blackmun not correct when he said in *Thornburgh*:

“A woman’s right to make that choice freely is fundamental. Any other result ... would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all”.  

In this passage, Justice Wilson touches on one of the most troubling aspects of the abortion debate. At its heart, it is a contest between competing conscience claims. Justice Wilson understands this but puts the choice starkly: if one person’s conscience is to triumph over another’s, surely the “winner” must be the one making the choice to abort. No one should be forced to undergo an abortion (or forced sterilization), for example, and in a eugenic contest of conscience between a pregnant woman and a physician who thinks she should not be allowed to have a baby, it is clear whose conscience we would support.  

As Justice Wilson notes in *Morgentaler* in assessing the absurdity of requiring a committee decision on whether an abortion proceeds:

The fact that the decision whether a woman will be allowed to terminate her pregnancy is in the hands of a committee is just as great a violation of the woman’s right to personal autonomy in decisions of an intimate and private nature as it would be if a committee were established to decide whether a woman should be allowed to continue her pregnancy.

The simplicity of “choice” allows a pregnant woman to make the decision (even if her choices are deeply constrained by economics, health, family, religion, and other factors). It is her conscience that prevails when

---


68 *Morgentaler*, supra note 47 at 172.
the pregnancy presents a challenge. In his recent article “The Right to Conscience,” Bernard M Dickens uses Justice Wilson’s decision in *Morgentaler* to highlight this fundamental premise:

> It is arrogant and impertinent for strangers to this woman’s circumstances, whether they have the power of legislators, the authority of judges, the piety of ministers of religion, or the learning and experience of doctors, to believe that their conscientious resolutions of this woman’s competing family interests are superior to hers.69

Richard Haigh refers to the process of reviewing the case law on freedom of conscience as a “Quixotic Journey.”70 He considers the Federal Court decision in *Maurice v Canada (AG)*71 to be the “apogee” of conscience jurisprudence and concludes, “[t]ogether with [Justice] Wilson’s decision in *Morgentaler*, it provides hope for my view that a differentiated conscience could, and should, flourish in Canada.”72 *Maurice* is a trial court decision granting a free-standing conscience right to a vegetarian diet in prison on ethical grounds. A former member of the Hare Krishna faith, Mr. Maurice renounced his faith but wanted to maintain his once religiously-inspired vegetarian diet.73 Correction Services Canada refused on the ground that there was no religious or spiritual need for the diet.74 The court held that Section 2(a) protected his right to a belief that the consumption of animal products is morally wrong and that the prison had no justification for denying him a vegetarian diet when that preference is accommodated under religious grounds.75 Justice Campbell offered this rationale:

> In *R. v. Big M Drug Mart Ltd.*, [Justice] Dickson stated that the rights associated with freedom of individual conscience

---


70 Haigh, *supra* note 63 at 117.

71 2002 FCT 69, 215 FTR 315 [*Maurice*].

72 Haigh, *supra* note 63 at 136.

73 *Maurice, supra* note 71 at para 3.


are central to basic beliefs about human worth and dignity, and that every individual should be free to hold and manifest whatever beliefs and opinions his or her conscience dictates. Justice Dickson further articulated the broad scope of [Section] 2(a) as follows:

Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.76

In Gonzales v Carhart Justice Ginsburg argued:

[T]his Court has repeatedly confirmed that “[t]he destiny of the woman must be shaped ... on her own conception of her spiritual imperatives and her place in society” ... (“[M]eans chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”)77

Whether the woman’s decision is easy or traumatic, the choice clear or agonizing, the only conscience that can ultimately prevail is the one guiding the woman’s choice to abort or not. She is the one who bears the full cost of the decision. She has the right to choose. Furthermore, conscientious objection to effective referrals to a physician who can counsel as to the full range of options available for pregnant women, “misconstrues the purpose of abortion referral ... which is not simply for abortion but for consideration of a range of legitimate options, of which abortion is one.”78 The case law on Section 2(a) freedom of conscience thus far supports a freestanding protection of a woman’s right to choose her maternal destiny as a matter of individual conscience that cannot be superseded by the state’s conception of what is good or right. While the majority of the Court in Morgentaler did not have to go this far in order to strike down the Criminal Code ban (and given the sensitivity of the issue, it is predictable that the Court would decide the issue as narrowly as possible), in my view Morgentaler would now

76 Ibid at para 11, citing R v Big M Drug Mart Ltd., [1985] 1 SCR 295 at 337, 18 CCC (3d) 385.
77 Gonzales, supra note 57 at 185.
78 Dickens, supra note 69 at 229–30.
be read, in combination with the Supreme Court’s Section 2(a) case law to pave the way for reproductive autonomy and access to contraception and abortion as Constitutional rights.

C. Conclusion on the negative rights or “defensive” Charter arguments

Assuming the Charter applies to physicians in the course of their treatment of patients, and given the Charter rights at stake for women in accessing reproductive care, the Courts will have to balance the competing constitutional rights. This is a familiar task. In the context of women’s reproductive rights, it is imperative that access to birth control and abortion be situated as a Charter equality right. It is equally necessary that we recognize a denial of access as a serious violation of a woman’s Section 7 rights to security of the person. Whether or not women pursue legal action against doctors for individual declarations of violations of those rights, any consideration of a physician’s rights to determine a course of treatment for women in their reproductive capacity must grapple with choice in the context of what is constitutionally at stake for women.

While in my view, physicians are subject to the Charter as state actors with a monopoly in delivering state-funded public health care, it will not be determinative of the balancing of rights if they are not. If women cannot launch a challenge under the Charter as against their doctors, they still have Charter rights to reproductive autonomy as freestanding claims. Women

---

79 For a recent decision on reconciling competing Charter rights, see R v NS, 2012 SCC 72, [2012] 3 SCR 726. The Court had to balance the freedom of religion of a Muslim complainant in a sexual assault case, who claimed a Section 2(a) right to wear a niqab while testifying, against the Sections 7 and 11 fair trial rights of an accused. The Court emphasizes: “[O]ur jurisprudence teaches that clashes between rights should be approached by reconciling the rights through accommodation if possible, and in the end, if a conflict cannot be avoided, by case-by-case balancing” (ibid at para 52). The balancing exercise is evocative of the Court’s approach under Section 1 of the Charter and asks judges to assess the salutary effects of preferring one right (in our context, the salutary effects of preferring a physician’s Section 2(a) or Section 15 rights) versus the deleterious effects on the competing right (in our case, the deleterious effects on a woman’s Sections 2(a), 7, and 15 rights). See the framework established in Dagenais v Canadian Broadcasting Corp, [1994] 3 SCR 835 at 886–90, 120 DLR (4th) 12; R v Mentuck, 2001 SCC 76 at paras 28–39, [2001] 3 SCR 442 (for further discussion of how lower court judges should approach the balancing of interests).
have Sections 2(a), 7, and 15 rights to both birth control and abortion. Legislative attempts to curtail those rights have been subjected to many legal challenges over the years. Even if doctors cannot be personally sued for violations, the free-standing rights of women operate to check the absolute exercise of physicians’ own Charter rights. I will elaborate this point below in my discussion on freedom of religion.

And so what of that balancing of rights? In whose favour does it lie? I will outline in greater detail below the shape and content of the rights claimed by physicians. In short, though, there is on the one side, the economic rights of an individual to his or her chosen employment, and on the other side, a woman’s right to control her body and determine her future as mother or not. I hope when presented as starkly as this, it is clear which side “wins.”

Bernard Dickens describes a judgment by Chief Judge Posner of the US Court of Appeals in *Rodriguez v City of Chicago*. In the case, a police officer assigned to protect an abortion clinic against protesters’ violence and assaults objected to the assignment as he considered it would facilitate abortion, contrary to his Roman Catholic beliefs. Judge Posner concluded that he was an agent of the State performing a public function and was not free to choose what or whom he would protect, just as a firefighter could not choose to let the abortion clinic burn down. “By analogy,” offers Dickens, “doctors should not deny lawful procedures that patients want when they are

---

80 Some of those who made submissions to the College during its consultation period for revising the Policy took the opposite view on who should suffer the consequences of a clash between a physician and patient on a course of treatment:

Ultimately, patients should have the final say in their treatment. Please do not interpret this submission as a call for doctors to force their will on their patients. However, there is a clear line between a patient having the final say in their treatment and patients forcing a particular health practitioner to then be involved in that line of treatment. A patient can get another doctor. No patient should have the right to force a particular doctor to do anything against the doctor’s conscience (Association for Reformed Political Action Canada, “Re: Request for Submissions on Policy Statement #5-08” (5 August 2014), online: <www.arpacanada.ca/attachments/article/2024/ARPA%20Canada%20Submission%20to%20CPSO%20Human%20Rights%20Policy%205-08.pdf>).

81 Dickens, *supra* note 69 at 233; 156 F (3d) 771 (7th Cir 1998), 77 Fair Empl Prac Cas (BNA) 1421 [*Rodriguez* cited to F (3d)].
the only ones trained, qualified, and available to undertake them on the basis of their personal beliefs.\footnote{82}

### III. The Positive Rights Claims or “Offensive” Charter Arguments

I have outlined above the negative rights claims or “defensive” Charter arguments presented by the Applicants in this case: that individual physicians are not subject to the Charter in the performance of their duties as physicians. This is the lesser claim arising in this case and while I think it raises important questions as to the balancing of rights at stake, the heart of the Application is in the Applicants’ claim to their own Charter rights and protections. Specifically, the individual Applicants argue rights under Section 2(a) freedoms of religion and of conscience, as well as Section 15 equality rights.\footnote{83} I begin this Part with a brief overview of the conscience and religion claims at issue. What lies beneath the constitutional arguments? What is the philosophical justification for alleging a right to practice medicine in accordance with one’s conscience? I will then examine the specific Charter arguments of the physicians in turn.

#### A. Conscience exemptions in health care

Before turning to the legal claims made by the Applicants, the article will briefly consider the bioethical contours of two aspects of the debate. There is significant literature on conscientious refusal or objection by physicians and it is beyond the scope of my legal analysis to do it proper justice here. I think it valuable, however, to have some sense of the philosophical issues at play in understanding their influence on the legal analysis of the College’s Policy.\footnote{84} Two discussions are particularly relevant. First is the issue of ordering protections for religion and conscience claims, and the

\footnote{82} Dickins, \textit{supra} note 69 at 233.

\footnote{83} Notice of Application, \textit{supra} note 1 at 3.

\footnote{84} \textit{Supra} note 6. An interesting aspect to conscience claims that is not relevant in this context, but which shapes the debate elsewhere, is a physician’s assertion of conscience protections not to be complicit in unethical or unlawful acts. Physicians argue, for example, that it is unconscionable to participate in abhorrent medical experiments on prisoners or patients with mental illnesses. Arguments that physicians should not be forced to participate in either ethical or legal violations offer support to arguments for conscientious objections, but
need to position both personal and social expectations in formulating workplace protections for objectors. Second is the development of philosophical arguments for the moral necessity of both referral and urgent care in the medical context.

1. The bioethical dimensions to religion and conscience

Bioethicist Daniel Weinstock describes a distinct “conscience” claim as founded in the citizen as a reflective moral being with an “ability to reflect upon moral issues and controversies that arise in her community or elsewhere and arrive at judgments about what the right thing to do is in such controversies.”

Moral reasoning by one’s conscience is distinct from a different normative consideration brought to bear in one’s life through religion. Religious claims derive from tradition and the shared practices and rituals of membership in a community.

According to Weinstock, conscience is an outward manifestation of belief that enables a more fulsome democracy and encourages participation in civic society. Religion is more internal and shapes the self (as opposed to shaping society). Weinstock characterizes the key difference between conscientious integrity and religious integrity this way:

Whereas the former protects the process and the results of moral reflection, the latter protects the agent’s ability to continue to participate in rites and practices, and to follow communal rules, the principal function of which have to do with individual identity, with the need felt by many people actively to identify with a temporally extended, rule-governed community in order to forge a stable sense of identity.

---

86 Ibid.
87 Ibid.
88 Ibid at 11 [emphasis in original].
Given the difference, and supported by the Charter’s articulation of conscience and religion as separate fundamental freedoms under Section 2(a), Weinstock argues there can and should be different protections assigned to each. Conscience is deserving of a higher degree of protection in the health care field than religion should be accorded. He describes several reasons to protect conscience claims by health care providers. First, as moral agents, physicians need space to express themselves. Second, health care institutions benefit when providers “reflect about the laws, rules, codes of conduct and protocols that govern their professional practice.” Third, the health care field has many issues that present moral quandaries and controversies. Recognizing conscience claims acknowledges that as individuals, health care providers are reflective of the divide in society over difficult questions. These reasons justify recognizing conscientious objection by health care providers (though they do not lead to an inevitable conclusion as to the limits of accommodation or the reconciliation of competing claims).

These reasons do not apply in the case of religion, however, and, for Weinstock, the case for recognizing religious claims in health care provision is a weaker one. He argues that the benefits of recognizing conscience rights accrue to institutions (and therefore to the larger society),

by helping us to get clearer than we might otherwise have been on controversial moral issues to which the arguments grounding her refusal contribute, or by opening our eyes to unjust or unethical practices that have seeped their way into medical practice as a result of the application to the decision-making process within the [health care] sphere of the wrong kinds of pressures and interests.

On the other hand, no such institutional or larger societal benefits accrue from a recognition of religious rights which are entirely personal to an individual or as Weinstock puts it, “identity-stabilizing.” Weinstock acknowledges that Bills of Rights (like the Charter) offer protections for freedom of religion but points out that these merely enable believers to live within the dictates of their faith. This does not mean they have an additional entitlement to practice a particular profession within the dictates of that faith. He concludes:

89 Ibid.

90 Ibid at 13.
It is not central to the practice of any religion of which I am aware that the faithful are required to practice a specific profession. Where the dictates and prescriptions of a religion make demands upon the faithful that would be dysfunctional in a particular professional setting, and where a particular individual feels unable to deviate from these prescriptions, it does not seem unreasonable to require of her that she practice a profession that can more easily accommodate the demands that they place upon her.91

If one accepts Weinstock’s assertion that conscience claims are deserving of a higher order of protection than religious claims, what is the meaning of conscience? Bioethicist Carolyn McLeod describes the dominant view of conscience as focused on internal harmony or integrity. She outlines two dimensions to conscience:

(1) [B]eing alert to signs of discord between one’s actions or thoughts and one’s deep moral commitments; and (2) being inclined to assuage the discord. The “voice” of conscience is this alertness and this inclination –our conscience “speaks” to us when we are attentive and prepared to eliminate inner moral discord.92

McLeod takes a different view than Weinstock on the personal versus social aspects of conscience and religious rights. McLeod suggests that the dominant philosophical view on conscience is not sufficiently relational whereas Weinstock justifies conscience protections as based on the rela-
tional value of ethical reflection. McLeod argues that ethicists do not give adequate regard to the constant social shaping of conscience:

Granted, the dominant view is not as extreme as some religious views that instruct us to tune in to our conscience and put our lives in conformity with it, without questioning what it says. Advocates of the dominant view do accept that at times we might, or indeed should, scrutinize the demands of our conscience. However, they do not associate the value of conscience with its ability to inspire attempts at taking responsibility for what we value.93

For McLeod, the social value of retooling one’s conscience should lead to reflective practice training for health care professionals.94 A physician with a well-functioning conscience with respect to reproductive rights for women should have some understanding of how their conscientious objection to referral or provision of service affects women. She argues that “any right to have one’s conscience protected should be accompanied by a duty to ensure the cultivation of a well-functioning conscience.”95 In my view, McLeod’s argument is significant to a legal assessment of this Notice of Application to understand conscience claims as both personal and requiring constant self-reflection and revision in the face of socially-competing conscience views. It is philosophically insufficient to simply assert a conscience claim without understanding it as personal (and therefore subject to overriding claims with a greater social benefit) and contingent (and therefore subject to requests from a regulatory body that the impact of one’s conscience be reconsidered or limited in the face of competing social claims). Chloë Fitzgerald argues that the dominant view of conscience has a serious flaw in its focus on explicit attitudes at the expense of implicit attitudes or biases.96 In the context at issue here around conscience refusals in reproductive care, I argue that physicians who have unexamined but implicit attitudes about the proper role of women may not adequately reflect on the role those biases play in their conscientious objections.

93 *Ibid* at 173.

94 *Ibid* at 176.

95 Fitzgerald & McLeod, *supra* note 21.

2. The moral argument for referral

Carolyn McLeod makes a forceful argument that those concerned with increasing access to reproductive rights for women must engage in the “battle” over physician referral as the “pro-life” side is winning.97 She describes the conflict as resulting in this compromise: “pro-choice people have agreed to allow conscientious objectors to opt out of performing abortions so long as these objectors make referrals for abortions.”98 However, those opposed to abortion see this as a false compromise, as it makes physicians complicit in the performance of acts they find morally forbidden. This is the basis of the physicians’ objections in the Notice of Application to the referral clause in the updated Policy. In McLeod’s view, the case for abortion is morally justified, and hence, doctors should have to perform them.99 The case for a lesser obligation – that of a referral – is permissible only where that referral is accessible to the patient.100 If not, the doctor should have to perform the service. The justification for allowing a referral is patient well-being: “Simply put it is better for patients to have physicians who can perform abortions with as little professional distance as possible given how emotionally trying abortions can be for patients.”101 However, she points out, “patients who want or need abortions are generally better off getting an abortion from a conscientious objector than not getting an abortion at all … On my approach, whenever referral is not possible, performance is required.”102 This is a stronger position than taken by the College. The Policy on provision of service conditions the requirement in the context of an emergency, “where it is necessary to prevent imminent harm.”103

In drafting a model Conscientious Objection Policy, McLeod and her colleagues Jocelyn Downie and Jacquelyn Shaw frame the treatment requirement more broadly, in keeping with McLeod’s views on the moral justifications of conscience refusals:

---


98 Ibid.

99 Ibid at 42, 48.

100 Ibid at 42.

101 Ibid.

102 Ibid.

103 Policy 2-15, supra note 6 at 5.
5.4 Treating Patients: When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient’s health or well-being, physicians must provide the patient with all health services that are legally permissible and publicly funded and that are consented to by the patient … This obligation holds even in circumstances where the provision of health services conflicts with physicians’ deeply held and considered moral or religious beliefs. 104

Their model section on information provision is much broader than that of the College, specifically requiring that “[p]hysicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.” 105 The Policy as passed by the College states:

Physicians must provide information about all clinical options that may be available or appropriate to meet patients’ clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs. 106


105 Ibid. As noted above in describing the Notice of Application, the physicians have not expressly objected to the requirement of information provision but since it is included in the objectionable section on effective referral, presumably they take issue with it as well. There are many anti-abortion arguments grounded in the “harm” that abortion causes to women. In the US Supreme Court decision in Gonzales for example, the majority judgment by Justice Kennedy argued: “While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained severe depression and loss of esteem can follow” (supra note 57 at 159) [footnotes omitted]. This aspect of the decision was very controversial and gave judicial credence to so-called “scientific” evidence that abortion is medically harmful to women. Counselling and information provision policies for physicians must be careful to account for the provision of information that a physician personally believes true and helpful, but that is grounded in implied biases and fake science. For an analysis of this aspect of the Court’s decision, see Ronald Turner, “Gonzales v Carhart and the Court’s ‘Women’s Regret’ Rationale” (2008) 43 Wake Forest L Rev 1.

106 Policy 2-15, supra note 6 at 6.
The Policy as recently reformed by the College attempts to strike a balance between a respect for the consciences of physicians, and the need to provide necessary medical services. An individual’s right to hold religious, ethical, or conscientious beliefs does not legally entail a concomitant right to impose those beliefs on others. The right to believe is much broader than the right to act on beliefs. Allowing physicians to act on their conscience by refusing to treat women with contraception or abortion goes too far in respecting a physician’s private and personal ethical boundaries.

B. The Applicants’ Charter claims: The constitutional rights of physicians

At last we come to the heart of the Notice of Application as filed by the physicians and their advocacy organizations. While their defensive position is important in setting out any balancing of rights that needs to happen, their primary argument is in favour of their own individual rights as physicians. It is important to note with precision their claim: this is not about their individual rights as private persons. The Notice of Application is firmly centered on the rights of physicians in the performance of their professional duties as doctors. They claim three separate Charter protections: freedom of religion, freedom of conscience, and equality rights.

1. Section 2(a) freedom of religion

The test to determine a Section 2(a) freedom of religion violation was set out by the Supreme Court of Canada in Syndicat Northcrest v Amselem. A majority of the Court held:

[A]n individual advancing an issue premised upon a freedom of religion claim must show the court that (1) he or she has a

---

107 The updated Policy also alludes to the obligation on physicians not to abandon a patient. In its discussion on advising patients of limitations to clinical competence it states: “In order to protect patients’ best interests and to ensure that existing patients, or those seeking to become patients, are not abandoned, the College requires physicians to provide a referral to another appropriate [health care] provider for the elements of care the physician is unable to manage directly” (ibid at 4).

108 Notice of Application, supra note 1 at 3.
practice or belief, having a nexus with religion, which calls for a particular line of conduct, either by being objectively or subjectively obligatory or customary, or by, in general, subjectively engendering a personal connection with the divine or with the subject or object of an individual’s spiritual faith, irrespective of whether a particular practice or belief is required by official religious dogma or is in conformity with the position of religious officials; and (2) he or she is sincere in his or her belief.109 The Court is careful and clear that the belief need not be one that is “required” by the religion and it need only be a belief that the claimant feels connects him or her with the divine. Sincerity will be a matter of credibility but the Court is also clear that, “[b]ecause of the vacillating nature of religious belief, a court’s inquiry into sincerity, if anything, should focus not on past practice or past belief but on a person’s belief at the time of the alleged interference with his or her religious freedom.”110 If the claimant is successful at establishing a sincere belief in a practice that connects her or him to the divine, the Court then requires a claimant to show that the interference with religious belief is “more than trivial or insubstantial.”111

Given that many religions oppose abortion, and that there are strong religious arguments against both it and birth control, I do not doubt that the Applicants will succeed at this stage. All five individual Applicants are described as “committed” to their religious beliefs. Four are Protestant Evangelicals and one is Catholic. Both traditions have theological leaders who support a ban on contraception and abortion.112 These first two parts of the freedom of religion test should pose no problem for the Applicants.

The final phase may be more challenging. Once a sincerely held religious belief is implicated and the claimant has shown that the interference is


110 Ibid at para 53.

111 Ibid at para 59.

more than trivial or insubstantial, the Court must consider whether the belief should be protected in the matter at hand. In making that assessment, the Court emphasizes that freedom of religion claims cannot be examined in isolation – context is everything:

[O]ur jurisprudence does not allow individuals to do absolutely anything in the name of that freedom. Even if individuals demonstrate that they sincerely believe in the religious essence of an action, for example, that a particular practice will subjectively engender a genuine connection with the divine or with the subject or object of their faith, and even if they successfully demonstrate non-trivial or non-insubstantial interference with that practice, they will still have to consider how the exercise of their right impacts upon the rights of others in the context of the competing rights of private individuals. Conduct which would potentially cause harm to or interference with the rights of others would not automatically be protected. The ultimate protection of any particular Charter right must be measured in relation to other rights and with a view to the underlying context in which the apparent conflict arises.

The emphasized part of the quote from Amselem will be an obstacle for the Applicants in this case. In my view, it should bar the claim. There is a definite risk, likelihood, and even a certainty of harm when women are denied access to contraception and abortion. A refusal to provide an effective referral for abortion, or to perform the service when urgently required, will cause serious harm to women. As I argued above, I do not think

---

113 Amselem, supra note 109 para 60.
114 Ibid at para 62 [emphasis added].
115 I acknowledge that many religious people may take the position that pregnancy is never a harm to women. Although the physicians do not state this explicitly, it is implicit in their position that their oath to “First do no harm” guides them to believe that the harm comes from interfering with conception and pregnancy, and not from the condition itself. I do not doubt the sincerity of this belief for some physicians objecting on religious or conscientious grounds. However, in a patient-centred medical framework where patients are capable and autonomous in decision making, the physician’s assessment of harm must give way to the patient’s decision making. If a woman sees the pregnancy as a “harm,” in the context of a country where abortion is both legal and available, the physician’s opinion that it is not a harm is only that – an opinion – and not one that should determine the course of treatment.
that physicians can rely on non-objecting physicians to overcome this harm (nor do I think they are purporting to do so). In taking a contextual analysis to this claim, the Court must balance the physician’s right to practice his or her employment according to a religious belief as against a woman’s constitutionally protected right to access necessary and legal reproductive health care.\textsuperscript{116} Economics versus the body; a job versus a life. I do not think the claim can overcome the harm stacked against it. Physicians have no entitlement to their chosen profession (none of us do) and they certainly have no “right” to practice medicine in their chosen specialty. Medical students who anticipate a conflict between their conscience or religious beliefs, or both, do not have to enter into the practice of front line emergency or family medicine. There are specialties that would not pose the same moral, ethical, or religious conundrums to doctors. It is within this context that the claim to religious freedom must be understood. While there are appropriate instances for physicians to rely on their consciences to inform a course of action, those most often take place when patients request unlawful or medically unsound courses of treatment. Physicians should refuse to treat a patient in ways that will produce no medical benefit. The conscience claims asserted here are of a different sort and purport to replace a woman’s moral choice with the physician’s with respect to a procedure that is lawful and medically necessary when the pregnant woman believes it to be. While employment may be an important life interest, it is not as central or core to identity as bodily integrity and parenthood.

In my view, while the Applicants may hold a sincere religious belief that they cannot participate in facilitating or providing either abortion or contraception (or offering effective referrals for them), they will not be able to establish a non-trivial or substantial interference with that belief in light of the context of the claim. This is especially true with respect to the challenged clause on effective referral. A referral simply directs a patient to

\textsuperscript{116} In addition to balancing Charter rights, the Supreme Court also analyses Charter claims with a view to upholding international human rights obligations. Article 18(1) of the \textit{International Covenant on Civil and Political Rights} protects a right to freedom of religion, but it is qualified in article 18(3) which states:

\begin{quote}
Freedom to manifest one’s religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others (19 December 1966, 999 UNTS 171 (entered into force 23 March 1976, accession by Canada 19 May 1976)).
\end{quote}
another physician. Abortion may not even result from that referral as a fully informed patient may decide to proceed with the pregnancy. An objecting physician has no way to know what the course of treatment will be when a patient is counseled as to all available options. The degree of separation in decision making in the effective referral context may still be an uncomfortable position for physicians, but it makes the balancing of rights even more clearly in the woman’s favour.

The issues are more complicated in considering the Policy on urgent provision of services. There, a physician might well be able to successfully argue a lack of competence or training to provide the service. Still, a physician must consider his or her own limitations in choosing a medical specialty. A profession that requires a physician to perform all legal and funded services within his or her competence and choice of specialty does not force doctors into a certain line of practice. Physicians should be fully trained on all treatment issues likely to arise in their chosen field.

2. Section 2(a) freedom of conscience

The claim to a violation of freedom of conscience is presented as separate from the claim to a breach of freedom of religion. Presumably, the Applicants see a difference between these two protected freedoms. As described above, the Supreme Court of Canada agrees, though the difference is not yet fully articulated.

All of the Applicants in this case have self-identified as belonging to a specific religious group. It may therefore be difficult for these particular claimants to separate a unique conscience claim unrelated to their deeply held religious tenets, but others have made the case for a secular anti-abortion position.117 Assuming one could articulate a reasoned anti-abortion

---

117 See e.g. Kristine Kruszelnicki, “A Secular Case Against Abortion”, Pro-Life Humanists (13 May 2013), online: <www.prolifehumanists.org/secular-case-against-abortion>:

The late atheist author Christopher Hitchens, when asked in a January 2008 debate with Jay Wesley Richards whether he was opposed to abortion and was a member of the pro-life movement, replied:

I’ve had a lot of quarrels with some of my fellow materialists and secularists on this point,
belief, grounded in a scientific claim, or moral ethics, or some other firm conviction, in my view the Court would accept it as protected by freedom of conscience. Unlike freedom of religion where the Court has developed a “test” to be applied, freedom of conscience remains undefined. Presumably though, to keep the two clauses coherent, a similar test would apply. A freedom of conscience claimant would have to show that their conviction or belief is sincerely held and related as a matter of conscience[^118] and that within the context of their claimed freedom, the state inference was non-trivial or more than insubstantial. For the same reasons articulated above, this claim would fail on the last part of the test. The conscience claims, like the religious ones, pit a physician’s economic interests against a woman’s bodily integrity and equality rights. Clearly, the patient wins in this contest.

### 3. Section 15

Pursuant to the Kapp test for Section 15, the Applicants will have to first show a difference in treatment based on one of the enumerated or analogous grounds and second, that the differential treatment perpetuates or

[^118]: Dickens argues, “Conscience may be shaped by social, philosophical, political, professional, and other convictions apart from those founded on religious faith.” Interestingly in the context of my argument, he concludes:

Religious institutions and hierarchies that, for instance, do not include women, and that expressly exclude women from positions of doctrinal authority, may be considered conscientiously flawed, and to lack relevance in their pronouncements, particularly on a matter such as abortion, in which women’s health and interests are centrally involved (supra note 69 at 211).
exacerbates the disadvantage of the claimants. The equality aspect of the physicians’ claim is difficult to articulate and the Notice of Application does not lay out the specifics. I assume the physicians argue that they are treated differently from others on the basis of the enumerated ground of religion.

Teasing out the contours of the claim, there are two ways in which the new Policy could be said to treat these Applicants differently. First, the difference in treatment is that some employees are allowed to shape their work life around sincerely held religious beliefs and employers are required to accommodate. So, for example, some employees could refuse to work on Saturdays or Sundays (the Sabbath days), or could wear religious attire (kippot, turbans, niqabs) and unless there is a bona fide reason to refuse to accommodate, an employer would be obligated to do so. Meanwhile, these physicians are not accommodated in the practice of their religious faith (their sincerely held belief requires them not to engage in any supportive role around contraception or abortion). This results in a difference in treatment around aspects of religious belief (some aspects could lead to accommodation, other aspects do not). The difference in treatment is not based on a religion per se, as no particular religion is singled out in the new Policy, and opposition to contraception and abortion is not limited to a single religious sect or denomination. It is, however, a difference in treatment based on the religious practitioner’s manifestation of religious beliefs. This might be sufficient to pass the first step of a Section 15 analysis. Manifestation of beliefs is clearly part of our concept of religion. To the extent that the new Policy can be read as compromising a physician’s unbridled reliance on religious beliefs in decisions on how to practice front line medical care, while other religious manifestations around clothing or scheduling can be part of front line medical care, these physicians might be successful in arguing differential treatment from other religiously-minded physicians.

119 Kapp, supra note 56 at para 25.

120 None of the other enumerated or analogous grounds apply to this claim. The enumerated grounds are: “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” (Charter, supra note 2, s 15(1)).

121 I say “might” be successful in arguing differential treatment because another way to look at the Section 15 claim is to say that the College has made a decision that the asserted religious beliefs in this case cannot be accommodated. While the scheduling of physicians and rules around professional clothing have little to no impact on patient care, in this case the religious beliefs directly implicate patient care. The difference in treatment is then of a different quality altogether. In Withler v Canada (2011 SCC 12, [2011] 1 SCR 396) the Supreme Court of Canada did away with the rigid requirement that claimants point to a
Second, the Policy arguably treats religiously-minded physicians differently from secularly-minded physicians. This could be framed as directly discriminatory in that the burden of conforming to the Policy falls most dramatically on those who have religious objections to it. Or, the claimants might also be making an adverse effects discrimination claim, arguing that although the Policy is neutrally worded to require all physicians to make “effective referrals” or perform “urgent care,” it adversely impacts religiously-minded physicians for whom these new guidelines impose a disparate impact on the ground of religion. Non-religious doctors will face little to no change in their practice. Religious doctors may have to change practice focus or specialty. It would seem likely that the physicians could argue that the Policy is not a neutral one, and that in fact it was intended to coerce physicians to conform to the College’s position on patient care for women. The Policy arose in the context of a protracted debate about conscientious objection and was framed as the College’s definitive answer to physician obligations. The “adverse effects” in other words were not only contemplated but a necessary piece of the College bringing all front line service providers in line on this issue. The Policy therefore imposes adverse effects on some religious doctors, though these claims have been historically hard to establish at the Supreme Court of Canada.\(^\text{122}\)

---

\(^{122}\) See Jennifer Koshan & Jonnette Watson Hamilton, “The Supreme Court’s Latest Equality Decision: An Emphasis on Arbitrariness” (29 May 2015), ABlawg (blog), online: <abl awg.ca/2015/05/29/the-supreme-courts-latest-equality-rights-decision-an-emphasis-on-arbitrariness> [footnotes omitted] (commenting on Kahkewistahaw First Nation v Taypotat, 2015 SCC 30, [2015] 2 SCR 548 [Taypotat]). Taypotat is only the ninth adverse effects discrimination decision under the Charter from the Supreme Court in the last 30 years, and the number of successful adverse effects claims still stands at only two (see Eldridge, supra note 31; Vriend v Alberta, [1998] 1 SCR 493, 67 Alta LR (3d) 1). In our review of the Court’s adverse effects discrimination case law, we identified a number of problems arising in this type of case: the more burdensome evidentiary and causation requirements and assumptions about choice, the reliance on comparative analysis, the acceptance of government arguments based on the “neutrality” of policy choices, the narrow focus on discrimination as prejudice and stereotyping, and the failure to “see” adverse effects discrimi-
In my view it is likely the Applicants would succeed in establishing 
differential treatment on the ground of religion. This is not a crystal clear 
case, but the Court has moved away from a rigid comparative assessment 
in recent years and I think there is sufficient evidence here to move the an-
alysis along.\footnote{In my view it is likely the Applicants would succeed in establishing 
differential treatment on the ground of religion. This is not a crystal clear 
case, but the Court has moved away from a rigid comparative assessment 
in recent years and I think there is sufficient evidence here to move the an-
alysis along.}{123}

This would bring us to the second step of the *Kapp* test: does the differ-
ence in treatment perpetuate or exacerbate disadvantage? In *Kapp*, the Court 
made prejudice and stereotyping the focus of this second step in Section 
15(1). More recently, it seems to have shifted emphasis to the more broadly 
described notion of “disadvantage” and especially “arbitrary disadvantage.” 
In their piece analyzing the current state of Section 15 jurisprudence, Ko-
shan and Hamilton summarize the Supreme Court’s current majority pos-
tion:

Justice Abella refers to her reasons for the majority on the sec-
tion 15(1) issue in *Quebec v A* for the point that the equal-
ity section requires a “flexible and contextual inquiry into 
whether a distinction has the effect of *perpetuating arbitrary dis-
advantage* on the claimant because of his or her mem-
bership in an enumerated or analogous group.” Her judgment in 
*Taypotat* goes on to use the term “arbitrary” an additional five 
times. Arbitrary is used as a modifier of the term “disadvan-
tage”, as well as a synonym for “discriminatory.”\footnote{That said, in *Taypotat*, supra note 122, the Court dismissed the claim on the 
first step of the Section 15(1) analysis. The *Taypotat* case involved a commu-
nity election code adopted by the Kahkewistahaw First Nation in Saskatchewan 
to govern elections for the positions of Chief and Band Councillor. The 
price restricted eligibility for these positions to persons who had at least a 
Grade 12 education or the equivalent (ibid at para 5). The Court concluded, 
“[T]his case falls not on the existence of the requirement, but on the absence 
of any evidence linking the requirement to a disparate impact on members 
of an enumerated or analogous group” (ibid at para 14). The claimant in 
*Taypotat* argued that this qualification adversely impacted him on the analog-
ous ground of “residential school survivors without a Grade 12 education” 
(ibid at para 12).}{124}

That said, in *Taypotat*, supra note 122, the Court dismissed the claim on the 
first step of the Section 15(1) analysis. The *Taypotat* case involved a commu-
nity election code adopted by the Kahkewistahaw First Nation in Saskatchewan 
to govern elections for the positions of Chief and Band Councillor. The 
price restricted eligibility for these positions to persons who had at least a 
Grade 12 education or the equivalent (ibid at para 5). The Court concluded, 
“[T]his case falls not on the existence of the requirement, but on the absence 
of any evidence linking the requirement to a disparate impact on members 
of an enumerated or analogous group” (ibid at para 14). The claimant in 
*Taypotat* argued that this qualification adversely impacted him on the analogous 
ground of “residential school survivors without a Grade 12 education” 
(ibid at para 12).

\footnote{That said, in *Taypotat*, supra note 122, the Court dismissed the claim on the 
first step of the Section 15(1) analysis. The *Taypotat* case involved a community 
election code adopted by the Kahkewistahaw First Nation in Saskatchewan 
to govern elections for the positions of Chief and Band Councillor. The 
price restricted eligibility for these positions to persons who had at least a 
Grade 12 education or the equivalent (ibid at para 5). The Court concluded, 
“[T]his case falls not on the existence of the requirement, but on the absence 
of any evidence linking the requirement to a disparate impact on members 
of an enumerated or analogous group” (ibid at para 14). The claimant in 
*Taypotat* argued that this qualification adversely impacted him on the analogous 
ground of “residential school survivors without a Grade 12 education” 
(ibid at para 12).}{124}

\footnote{Supra note 122, citing Justice Abella in *Taypotat*, supra note 122 [emphasis in 
original].}{124}
This step could prove challenging for the physicians, assuming they can overcome the hurdle of establishing differential treatment on the basis of religion. Certainly religious discrimination is both a historic and present phenomenon and there is no doubt that many individuals have and continue to face disadvantage because of their religious beliefs. As a group and in certain situations, religious believers should be able to establish that they are disadvantaged in a secular society. This is true even though religious institutions are quite powerful in Canada (economically and politically). What will prove challenging is for the Applicants to show that the guidelines in the Policy perpetuate or exacerbate any alleged disadvantage. As I have already argued, the context of this case puts physicians at an acute imbalance in the assessment of their rights to employment as opposed to a woman’s right to reproductive autonomy. While it is undeniably true that the challenged Policies may make the practice of front line medicine more difficult for religious doctors, the Policies do not reflect any stereotypical thinking about religious doctors. They do not impose a particular disadvantage on doctors (who can choose a different specialty and still practice as physicians). They do not reflect the imposition of any arbitrary disadvantage. The Policies are far from arbitrary but are tied to a longstanding point of debate within the regulatory body and the result of extensive consultation about what a modern medical practice requires. Many life choices make the practice of a profession more difficult (the decision to have children, to live far away from one’s place of work, to engage in significant hobbies or pastimes that present scheduling challenges, etc.). The mere presence of “difficulty” is not “disadvantage” in the eyes of the Charter. These Policies may make front line medicine more “difficult” for religious physicians, but that difficulty is not a constitutionally recognized “disadvantage” under Section 15.

125 The individual Applicants in this case are supported in this litigation by religiously-focused advocacy organizations, formed to protect and advocate for the interests of their members. In a show of unity and strength, in a recent opinion piece in the Ottawa Citizen, three of the city’s prominent religious leaders called for the College to abandon the Policy’s requirement for effective referral: Reuven Bulka, Terrence Prendergast & Samy Metwally, “Rabbi Bulka, Imam Metwally and Reverend Prendergast: Doctors have a duty to their consciences”, Opinion, Ottawa Citizen (19 February 2015), online: Ottawa Citizen <www.ottawacitizen.com/news/national/doctors-duty-consciences>.
4. Section 1

If any of the Applicants’ Charter claims are successful, the analysis will move to the justification stage under Section 1:

The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.\textsuperscript{126}

The Court has devised a four part test for analyzing Section 1: 1) Is the objective of the legislation (rule, policy) pressing and substantial? 2) Are the means rationally connected to the objective? 3) Is there minimal impairment of the claimant’s rights? And 4) Are the salutary effects sufficiently important to justify the severity of the deleterious effects?\textsuperscript{127}

Most government initiatives pass the first stage and I think it likely the Court will find the College’s objectives here to be “pressing and substantial.” The Policy is meant to set out the professional and legal obligations of physicians to provide health services without discrimination. It does this in two ways: by imposing a duty to accommodate and by setting out expectations for physicians who limit health services because of either clinical competence or personal values and beliefs. The College uses the Policy as a way to make clear its expectations of physicians, and also to make clear to patients in Ontario what they can and should expect from their interactions with primary health care providers. Transparency, clarity, and non-discrimination in physician-patient relationships are clearly important goals for the regulatory body and thus the Policy should be considered a “pressing and substantial” objective.

Are the means set out in the Policy rationally connected to the objective? There have been many years of debate as to the scope of a referral requirement for religious or conscientious objectors.\textsuperscript{128} The College’s decision

\textsuperscript{126} Supra note 2.

\textsuperscript{127} This is known as the “Oakes” test from \textit{R v Oakes}, [1986] 1 SCR 103, 14 OAC 335.

\textsuperscript{128} See Downie, McLeod & Shaw, \textit{supra} note 104 at 28. The authors begin by recounting the furor over a 2006 guest editorial in the Canadian Medical Association Journal by Downie and Sanda Rodgers (former Dean, University of Ottawa Faculty of Law). Downie and Rodgers argued that it constitutes mal-
to make its expectations clear is rationally connected to its desire to ensure that patients receive non-discriminatory care from physicians, and to protect physicians who are also entitled to have their Charter rights respected. The amended Policy reflects a consultation process that culminated in the new guidelines. This is a rational means to accomplish the objective of transparency, clarity, and non-discrimination.

The most fragile step in the Section 1 analysis is often the minimal impairment phase. This is where the government usually fails if it loses a Section 1 argument. The College’s goal here is modest. It is not aiming to radically alter expectations on physicians, nor is it imposing new practice rules. While the Applicants may interpret the Policy as altering the status quo, the College would argue it simply clarifies what many saw as the existing legal requirements imposed by the Charter and the Ontario Human Rights Code. Even if it does alter the status quo, the Policy does so in an incremental way. Only two clarifications trouble the physicians: the duty to provide an “effective referral” and the duty to provide care in an emergency to avoid imminent harm. There are two ways these policies can be described as minimally impairing in the context here of balancing a physician’s rights and a woman’s reproductive rights.

First, it is rarely the case that a physician would be called upon to perform an emergency abortion that does not involve saving the life of the pregnant woman. Many of those who object to abortion concede that it should be available if the life or health of the pregnant woman is at stake. Even the most restrictive laws in the United States contain that exception.129

practice for physicians to fail to provide appropriate referrals, and in a subsequent letter to the editor reaffirmed that all physicians have an obligation, under the Canadian Medical Association (CMA) Code of Ethics and policy, to refer patients seeking abortion: Sanda Rodgers & Jocelyn Downie, “Abortion: Ensuring Access”, Guest Editorial, (2006) 175:1 CMAJ 9; Sanda Rodgers & Jocelyn Downie, Letter, (2007) 176:4 CMAJ 494. The Executive Director of the CMA Office of Ethics responded that they were mistaken as to the duty to refer (Jeff Blackmer, Letter, (2007) 176:9 CMAJ 1310). This debate (and uncertainty) carried on for years before the College clarified obligations after a series of consultations.

129 In South Dakota for example, women face a 72 hour waiting period between a State-required counselling appointment and the procedure and that counselling is expressly designed to deter her from proceeding with an abortion. Public funding for abortions is only available if the pregnant woman’s life is in danger and state plans under the federal Affordable Care Act only fund abortions if the
It is minimally impairing of a physician’s values to require the provision of an abortion in life-threatening circumstances. If a physician is willing to provide an effective referral, in a timely and supportive manner, the need for that physician to operate in emergency conditions is further reduced. When one considers that the Policy (and medical ethics generally) would allow a physician who is untrained or incompetent in the service to opt out of performance, this is further evidence of minimal impairment. The same is true for the provision of emergency contraception. This is a circumstance where it may be more likely an objecting physician has to provide the service. There is a dramatic time crunch to the prescription of the “morning after” pill (and some provinces allow pharmacists to dispense this over-the-counter). Still, an effective referral may relieve the physician of active participation, and for many objectors abortion is considered “worse” than contraception. Proper management and disclosure in counselling patients all mitigate the likelihood that “emergencies” will arise that implicate the direct, active involvement of an objector in care he or she objects to.

Second, it is clear that no individual has the right to a particular job. It is minimally impairing to expect primary care or front line physicians to be non-discriminatory in their treatment of all clients and to fully comply with the College’s support for all legal and necessary medical treatments. It is minimally impairing to expect that physicians who are uncomfortable with their role as primary care doctors to move to a different practice area that does not present the problematic ethical dilemmas. At this stage of the analysis, the College would have to demonstrate that it considered other alternatives but felt this one (the updated Policy) to be its best resolution of the problem. The fact that the College permits front line physicians to choose an effective referral (rather than the performance of all treatment of options, other than in urgent situations) is an appropriate and minimally impairing compromise of a physician’s religious, conscience, and equality rights.

Finally, considering the fourth step of the Section 1 analysis, the balancing of salutary and deleterious effects, it is evident that a woman’s right to bodily integrity and the right to non-discriminatory health care exceed a physician’s right to have his or her values define the care they will deliver within the scope of taxpayer funded employment. The decision to refer, or to perform an abortion, or to provide emergency contraception in urgent woman’s life is in danger. For further information and a breakdown of South Dakota’s law, see The Guttmacher Institute, “State Facts about Abortion: South Dakota” (2014), online: <www.guttmacher.org/pubs/sfaa/south_dakota.html>. 
situations, may pose a huge challenge to objectors. Similarly, the decision to abort or to seek birth control may be incredibly powerful and heart-wrenching moments for women. Given that contraception and abortion are legal medical services, the challenging decision is one the woman gets to make. It is her body, her psychological integrity, her life, and her future that are at stake. It is also her conscience that bears the greater brunt of the consequences of the decision. Physicians have significant interests but they cannot overcome those of the patient.

**Conclusion**

The College’s decision to updates its policy guidelines with respect to professional obligations comes after years of debate and controversy. That debate was largely centred on the issue of referrals to obtain an abortion, hence my focus here. It was within that context that the College clarified expectations: physicians who have a conscientious or religious objection to providing (or counselling around) a legal and publicly funded medical service must provide an effective referral to a colleague who can counsel fully and appropriately. In urgent circumstances, all physicians must provide all treatments they are professionally competent to provide. There is no longer any ambiguity around this issue. In many ways, this updated Policy simply brings the expectations of the College into compliance with the law. There is no legal ambiguity around women’s rights to contraception and abortion. Both are legal and women are entitled to equal access to them, regardless of where they live or who their front line physician happens to be. I predict the physicians will lose their legal challenge, as they should. The compromise struck by the College – that physicians can refer instead of perform the service themselves (unless it is an emergency) – is a compromise that recognizes and respects the rights of doctors while putting a priority on service to the broader public. In my view, physicians are subject to the Charter in the performance of their duties and must be alive to the claims they could face if they discriminate or endanger a patient by refusing to offer a legal and necessary medical service. The Policy strikes the appropriate balance and should be vigorously defended both by pro-choice advocates and by the larger population of autonomous decision makers who want to control their destinies.
MEDICARE AND THE NON-INSURED HEALTH BENEFITS AND INTERIM FEDERAL HEALTH PROGRAMS: A PROCEDURAL JUSTICE ANALYSIS

Michael Da Silva*

Procedural justice in health care goods and services allocation is a necessary, though likely insufficient, condition for a just health care system. Specific health care systems should accordingly be subject to procedural justice analyses. Norman Daniels and James E Sabin’s accountability for reasonableness framework is one of the best accounts of procedural justice in the health care allocation context. This framework requires the public display of decisions and the reasons for health care allocation decisions (“publicity” or “transparency”), the use of publicly accepted or acceptable rationales in those decisions (“acceptance” or “acceptability”), and mechanisms for

* Thank you to YY Brandon Chen, Julian Culp, Colleen Flood, Lisa Forman, Sophia Moreau, Sophie Nunnelley, Maxwell Smith, Lorraine Weinrib, and two anonymous reviewers for comments on earlier drafts and related works. Work on this article was conducted while I was a Senior Doctoral Fellow in the Comparative Program on Health and Society at the Munk School of Global Affairs and earlier drafts of some sections appear in the program’s working paper series. Thank you also to the Lupina Foundation for funding the program, the other fellows in that program, and the Canadian Institutes of Health Research (CIHR) Training Program in Health Law, Ethics and Policy for feedback on work on the issues discussed above. I also acknowledge and appreciate funding from CIHR’s Vanier Canada Graduate Scholarship program.

© Michael Da Silva 2017


challenging and/or appealing the decisions ("reviewability"); it may also require legal protection of the fulfillment of the first three conditions ("regulation"). These conditions provide clear metrics for assessing nations’ compliance with their framework account of procedural justice. This article accordingly applies that framework to three pillars of the Canadian health care system – Medicare, the Interim Federal Health Program, and the Non-Insured Health Benefits Program – to assess the extent to which Canada meets the demands of at least one influential account of procedural justice. It ultimately finds serious deficits in the publicity/transparency of the Canadian health care system, which makes it difficult to apply acceptability metrics, but identifies some progressive steps in better compliance with the publicity/transparency and reviewability components of the accountability for reasonableness framework. It also identifies non-drastic measures Canada can take to better achieve Daniels and Sabin’s vision of procedural justice in health care allocation.

publiquement acceptées / acceptables dans ces décisions (« acceptation » ou « acceptabilité ») et des mécanismes de contestation et / ou d’appel des décisions (« révision ») ; il peut également exiger une protection juridique quant à l’accomplissement des trois premières conditions (« réglementation »). Ces conditions fournissent des paramètres clairs pour évaluer la conformité des nations à leur cadre de responsabilité de justice procédurale. Cet article applique donc ce cadre à trois piliers du système de santé canadien, soit l’assurance-maladie, le Programme fédéral de santé intérimaire, et le Programme des services de santé non assurés, pour évaluer dans quelle mesure le Canada répond aux exigences d’au moins un cas influent de justice procédurale. Il constate finalement de graves déficits dans la publicité et la transparence du système de soins de santé canadien, ce qui rend difficile l’application de mesures d’acceptabilité, mais identifie certaines étapes progressives pour mieux respecter les composantes de transparence et de révision du cadre de responsabilisation de la raisonnabilité. Il identifie également des mesures non-drastiques que le Canada peut prendre pour mieux réaliser la vision de Daniels et Sabin sur la justice procédurale dans l’attribution des soins de santé.
INTRODUCTION

I. ACCOUNTABILITY FOR REASONABLENESS AND PROCEDURAL JUSTICE IN HEALTH CARE: AN OVERVIEW

II. THE APPLICABILITY OF THE ACCOUNTABILITY FOR REASONABLENESS FRAMEWORK TO THE CANADIAN HEALTH CARE SYSTEM

III. THE CANADIAN HEALTH CARE SYSTEM: AN OVERVIEW

IV. THE TRANSPARENCY REQUIREMENT: REASON-GIVING IN THE CANADIAN HEALTH CARE SYSTEM

V. THE PUBLIC ACCEPTANCE/ACCEPTABILITY REQUIREMENT: THE ADEQUACY OF REASONS FOR DECISIONS IN THE CANADIAN HEALTH CARE SYSTEM

VI. THE REVIEWABILITY REQUIREMENT: THE PRESENCE OF CHALLENGE/APPEAL PROCEDURES IN THE CANADIAN HEALTH CARE SYSTEM

VII. THE RIGHT TO HEALTH CARE AND PROGRESSIVE REALIZATION: A FURTHER CONCERN

CONCLUSION
INTRODUCTION

Identifying the health care goods and services (henceforth, “health care goods”) states should provide is notoriously difficult. While many agree that people ought to be able to access the health care goods they need, resource constraints entail a need for some form of rationing. An uncontroversial principle for identifying which goods and services should be prioritized remains elusive. Norman Daniels and James Sabin accordingly champion a procedural approach to identifying the health care goods that ought to be provided by the state.¹ A purely procedural understanding of health care justice may not account for all of its most important elements,² but their basic point about the need for procedural justice remains. The vast literature on Daniels and Sabin’s framework for ensuring a fair process of selection is a helpful starting point for studying whether health care systems meet the demands of (at least one influential account of) procedural justice. Daniels and Sabin articulate their “accountability for reasonableness” (AFR) framework in several works.³ Other authors apply Daniels and Sabin’s indicia of fair processes to real world contexts. The resultant literature includes pieces that assess how the mainstream Canadian health care system, “Medicare,” fares from an AFR perspective; still other works apply the AFR factors without directly appealing to that framework as part of related examinations of pro-

---

¹ Norman Daniels & James E Sabin, Setting Limits Fairly: Learning to Share Resources for Health, 2nd ed (New York: Oxford University Press, 2008) at 10 [Daniels & Sabin, Setting Limits] (“Justice requires limits to care, and the lack of consensus on principles of distribution means that we must develop an acceptable fair process for setting limits and learn how to apply that process in real-world situations”).


Medicare and the non-insured health benefits and interim federal health programs: a procedural justice analysis

This work updates that research on Medicare’s accountability for reasonableness bona fides in light of recent developments and provides additional facts and analysis. It also expands the analysis of the Canadian health care system’s AFR by analyzing two group-specific health care programs that form part of the Canadian health care system: the refugee claimant-focused Interim Federal Health Program (IFHP) and the Aboriginal claimant-focused Non-Insured Health Benefits Program (NIHBP).

My update begins with three Parts that provide basic information about AFR, the Canadian health care system, and why it is appropriate to assess the latter in light of the former. The next three Parts examine the extent to which Medicare, the IFHP, and the NIHBP include three components required by the AFR framework: public display of decisions and the reasons for those decisions, the use of publicly accepted/acceptable rationales.

---


5 I should make two notes about terminology. First, the standard short form for the Non-Insured Health Benefits Program is “NIHB,” but I use “NIHBP” for grammatical reasons. Second, as Constance MacIntosh notes, “[t]he term ‘Aboriginal’ is unique to Canada and Australia,” may not reflect Aboriginal self-understanding, and could impose homogeneity at odds with facts: “Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations” in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, Canadian Health Law and Policy, 4th ed (Toronto: LexisNexis, 2011) 575 at 578–89. “Aboriginal” is thus an imperfect term for comparative analyses and may be more broadly problematic. Given the use of the term in Canadian constitutional law, however, it has some value here. Even MacIntosh notes that the Constitution clearly states that the term “Aboriginal” “includes,” but is not limited to, “Indians, Inuit and Métis” (ibid). It is thus a useful catch-all (though the fact that some powers are only discussed in terms of “Indians, Inuit and Métis” complicates the picture somewhat).
in those decisions, and mechanisms for challenging and/or appealing those decisions. I first confirm earlier work suggesting that Canada fails to provide (adequate) reasons for its Medicare decisions. I further demonstrate that even some appeal bodies are not bound to make the reasons for their decisions public. I argue that the online provision of reasons by some appeal bodies counts as an expansion of Canada’s reason-giving component of AFR, but go on to note that the NIHBP is more transparent than Medicare or the IFHP. I then provide an original take on two different ways one can understand the publicly accepted/acceptable rationale criterion and argue that Canada’s reason-giving deficiencies make it difficult to determine how Canada fares on either construal of the requirement (at least without engaging in potentially costly appeals). In the next Part, I provide an overview of the challenge/appeal mechanisms in Canada; I update the list of Canadian provinces with administrative appeal boards for health care allocation decisions found in some earlier publications and I add treatments of provincial ombudspersons and Aboriginal appeal mechanisms. A seventh Part provides an original take on the possible implications of this framework for Canada’s progressive realization obligations. A conclusion follows. Ultimately, this updated and expanded analysis suggests that Canada should embark on substantial improvements in its realization of the first two components of AFR, but that Canada’s score on the first metric is improving and its score on the third metric may be higher than earlier work suggests.

I. ACCOUNTABILITY FOR REASONABLENESS AND PROCEDURAL JUSTICE IN HEALTH CARE: AN OVERVIEW

Daniels and Sabin advocate for the distribution of health care goods in conformity with the basic demands of political justice. Their approach rests on an argument of the following form:

Premise 1: The distribution of health care goods is a concern of distributive justice.⁶

Premise 2: Authority for distributive justice vests in the public.

---

⁶ Daniels, at least, made this claim well before he developed the accountability for reasonableness framework with Sabin: Norman Daniels, Just Health Care (Cambridge, UK: Cambridge University Press, 1985) ch 3 [Daniels, Health Care].
Premise 3: Authority for the distribution of health care goods vests in the public\(^7\) (from Premises 1 and 2).

Premise 4: Where public authority is given to a representative body, such as the government, the representative body’s decisions must still be responsive to the public entity from whom the body receives its delegated authority.

Premise 5: Distributive decisions about health care goods are made by some form of representative body.

Conclusion: Thus, distributive decisions with respect to health care goods must be responsive to the public (from Premises 3–5).

Daniels adopts Premise 1 because health care is required for fair equality of opportunity,\(^8\) but it can just as easily be derived from the fact that health care goods are a bounded, valuable resource\(^9\) and/or that there is a social obligation to meet people’s health needs (andrationing is required to maximally meet these obligations).\(^10\) Premise 2 follows from a complicated account of public authority that I cannot detail here.\(^11\) Yet where Premise 2 is consistent with my claims about government authority above, it is granted for the sake of argument. Premise 5 is complicated by the fact that in practice many decisions are made by non-representative bodies, including authoritative rulers or their proxies. Yet, where one takes Premise 3 seriously, just health care decision making is only possible where the conditions in Premise 5 obtain; the only legitimate government or corporate authority for health care

\(^7\) See e.g. Daniels & Sabin, “The Ethics”, supra note 3 at 58.

\(^8\) See e.g. Daniels, Health Care, supra note 6 at 39–42; Daniels & Sabin, “Limits”, supra note 3 at 311–12.

\(^9\) This point is suggested by Daniels & Sabin, Setting Limits, supra note 1 at 1–2.

\(^10\) Daniels and Sabin explicitly make this claim in Daniels & Sabin, “Limits”, supra note 3 at 310–12.

\(^11\) It partly rests on claims about the conditions under which people will accept decisions made by others on their behalf. For example, Daniels and Sabin suggest that the public must view distributive decisions as legitimate and fair to accept them, but it is not strictly based on a consent-based model of authority (ibid at 304–06).
decision making is delegated authority. Thus, all health care decision making should be responsive to the public.\textsuperscript{12}

Ideally, some universal principle would determine how distribution should take place, simplifying the action in the Conclusion. For instance, few would challenge the assertion that need is a good reason to prioritize certain goods. A principle whereby “all persons should receive the health care goods they need” is appealing in the goods and services prioritization context. Yet Daniels’s earlier work suggests that even this uncontroversial principle is unlikely to solve the broader problem in light of the scarcity that requires us to prioritize goods and services in the first place. The principle leaves an important question open: “Even if we decide that access to health care should be based on need for services, which needs should we meet when we cannot meet all?”\textsuperscript{13} Further principles need to be invoked to ensure fair distribution. One may, for instance, seek to prioritize goods in light of the values they promote.\textsuperscript{14} Yet Daniels and Sabin’s work suggests that even if health care allocation decisions were made on the basis of the best ethical principle we could conjure, this alone would not provide legitimacy to decisions on the basis of that principle. Political legitimacy for invoking that principle would still be required. There can be, and is, reasonable disagreement over many political concerns.\textsuperscript{15} This reasonable disagreement arguably not only concerns the principles that determine how we ought to prioritize the distribution of certain goods, but also the status of values that could be used to justify new principles for the prioritization and distribution of health care goods, like “utility” and “equality”, and how best to understand basic concepts underlying these principles, like “need” and “opportunity.” Daniels and Sabin point to this “lack of consensus” on principles for decision making in the health care context.\textsuperscript{16} There may also be a lack

\textsuperscript{12} This explains why they hold that their framework ought to prescribe principles for decision making by private entities as well, even though these entities arguably do not derive their authority from the public.

\textsuperscript{13} Daniels, \textit{Health Care, supra} note 6 at 15.

\textsuperscript{14} Daniels’s prioritization of the goods that are required for fair equality of opportunity arguably takes this form. See \textit{ibid} at 49–50.


\textsuperscript{16} Daniels & Sabin, \textit{Setting Limits, supra} note 1 at 2–4, 10, 204. See also Daniels
of consensus on the meaning of terms underlying those principles. These phenomena help explain Daniels and Sabin’s affiliation of their work with the deliberative democracy model. Representative decision makers must respond to the needs of a wide constituency that includes people with radically different views on health care allocation. Responsiveness accordingly entails engaging with people with a variety of views. Infrastructure may be required to ensure this responsiveness to real people occurs. Fulfilling their Conclusion’s demands from the armchair is difficult.

In light of these concerns, Daniels and Sabin create further conditions for a fair process of distribution that is responsive to the public who maintain authority over decision making. The conditions necessary for these demands of distributive justice to be met fall under the title of “accountability for reasonableness.” There are four basic conditions. The “Publicity Condition” requires that reasons for decisions be provided and that they be made public. The “Relevancy Condition” requires that those reasons be relevant to health care decision making. The “Revision and Appeals Condition” requires that decisions be subject to challenge and/or appeal and capable of revision in light of these challenges. The “Regulative Condition” requires “some form of regulation to ensure that the other conditions are met.” The first three conditions require three metrics. In the most succinct statement of the necessary conditions of AFR, Daniels states that a health care process is fair only if it involves


They do, however, suggest that their argument for accountability for reasonableness can succeed independently from a commitment to deliberative democracy: Daniels & Sabin, “Limits”, supra note 3 at 307.

Daniels & Sabin, Setting Limits, supra note 1 at 11–12, 45.

Ibid at 12. It has also been referred to as the “Relevance Condition”: ibid at 45, 169; Daniels & Sabin, “The Ethics”, supra note 3 at 57. Per the formulation in “The Ethics,” the ultimate rationales for decisions “must rest on evidence, reasons, and principles that all fair-minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints” (ibid).

Daniels & Sabin, Setting Limits, supra note 1 at 45. This condition was originally just the “Appeals condition”: Daniels & Sabin, “The Ethics”, supra note 3 at 57.

Daniels & Sabin, Setting Limits, supra note 1 at 12, 45. This condition was once the “Enforcement condition”: Daniels & Sabin, “The Ethics”, supra note 3 at 57.
transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them. …

Fair procedures must also be empirically feasible. They must involve practices that can be sustained and that connect well with the goals of various stakeholders in the many institutional settings where these decisions are made.\(^{22}\)

To count as fair, in other words, a method for selecting what goods a given nation’s health care system should provide ought to include:

(1) the public display of the product of, and reasons for, decision making (“publicity” or “transparency”);

(2) the use of publicly accepted (or at least publicly acceptable) rationales in those decisions (“acceptance” or “acceptability”); and

(3) procedures for challenging and/or appealing the initial decisions (“reviewability”).

For Daniels and Sabin, then, the responsiveness in the Conclusion has three components: decision makers must make decisions that the public would (and perhaps do) accept, make these decisions known to the public, and be open to public challenges to those decisions. These conditions are jointly supposed to provide conditions for fairness in health care decision-making processes. They also serve as metrics for measuring that fairness. One may look for these structural features of health care systems to assess whether they meet the demands of AFR. The Regulative Condition could then require legal protection thereof. One may label the requirement for the legal protection of (1)–(3) – for example, through binding legislation – “(4).”\(^{23}\)

\(^{22}\) Daniels, “Accountability”, supra note 15 at 1300.

\(^{23}\) It is difficult to see how one can ensure that the first three conditions will be met without proper entrenchment. Yet Daniels does not make this claim and instead later states that the condition can be met by (4*) “voluntary or public recognition of the process” short of full legal protection: Norman Daniels, Just Health: Meeting Health Needs Fairly (Cambridge, UK: Cambridge University Press, 2008) at 119 [Daniels, Just Health]. I am not sure how to measure (4*) and thus stick to the blunt fact of (4) here. International human rights law prefers legislative entrenchment of social rights protections and thereby supports a
Now that the basic features of the AFR framework are clear, I can examine the extent to which this framework should and can be used to assess particular contexts. The AFR conditions were developed due to concerns about managed care organizations and framed as conditions on decision making for “insured patients.” Given the centrality of the notion of the public to Daniels and Sabin’s view, it would be reasonable to think that their conditions are meant to apply primarily to public health insurance regimes, but managed care organizations are private entities, and the problem Daniels and Sabin identify is a universal one. Prioritization decisions must be made in all systems of health care delivery. This suggests that the AFR framework can be applied to a variety of contexts. Indeed, Daniels’s later work on health justice not only expands the scope of his subject to include the social determinants of health, but also broadens the geographical scope of his inquiries. The reasons listed in the following section suggest that the AFR framework can at least be applied to Canada. Further sections then apply the framework.

II. The Applicability of the Accountability for Reasonableness Framework to the Canadian Health Care System

Even if one holds that Canada’s “public/tax-financed” health care system is not a traditional health insurance-based health care system, there are at least three reasons why it is appropriate to apply the AFR framework to the Canadian health care system. If one quibbles with one of those reasons, I am hopeful that the other two will be sufficiently convincing. First, the


25 See e.g. Daniels, Just Health, supra note 23 at ch 3–4 (examining the just distribution of the social determinants of health and its relationship with the AFR framework), 10 (examining AFR in developing countries with a primary focus on Mexico).

framework is specifically tailored for the evaluation of the procedural fairness of health care systems in liberal states. The impetus for the framework is the aforementioned “lack of consensus” on principles for decision making that clearly arises in liberal states. Daniels identifies the lack of consensus as a problem for “pluralist” states; empirical research confirms that public opinion on social justice, including principles of distributive justice, varies. The earliest in-depth application of AFR thus focused on the United States of America. Similar disagreements exist in Canada. The persistent lack of unanimity on whether cosmetic dentistry or in vitro services ought to be publicly insured arguably stems from more fundamental disagreements about principles for decision making. Canada’s status as a liberal democracy, then, suggests that the Canadian health care system is the type of entity to which the AFR framework can be applied. Indeed, Canada was mentioned in the first article outlining the AFR framework. This suggests that Daniels and Sabin’s understanding of a health insurance-based regime is broad enough to include the Canadian health care system; even if this is an improper characterization of the Canadian health care system, Canada remains a liberal democracy.

Second, Canada’s commitments to administrative justice and non-discrimination (as an aspect of administrative justice and as a standalone value) both imply that public decision making in Canada ought to be reasonable. Administrative justice demands that administrative decisions be made on the basis of reasons. The AFR framework provides resources for assessing the extent to which these reasons are given in a particular context and

27 Daniels & Sabin, Setting Limits, supra note 1 at 2–4, 10.

28 See e.g. Daniels, “Accountability”, supra note 15 at 1300.


32 Daniels & Sabin, “Limits”, supra note 3 at 308, 324, 334.

33 See e.g. the discussion of Baker found at 129, below.
provides metrics for assessing the extent to which decision makers are account-able for their commitment to this aspect of administrative justice. As Colleen M Flood points out, the AFR “factors map onto our understanding of the basic requirements for procedural fairness.” Non-discrimination, in turn, is a principle of Canadian law and many international legal documents to which Canada is a party. It also requires procedural safeguards for ensuring discriminatory reasons are barred from decision making. AFR can provide that bar. Where the Canadian health care system is in the domain of public administrative decision making and where Canada is committed to administrative justice and non-discrimination, it is appropriate to apply the AFR framework to that system.

Finally, the AFR framework provides good metrics for examining the extent to which the procedural elements of the international right to health care that Canada bound itself to realize are safeguarded. Canada is a signatory to several international covenants that recognize a “right to health.” One aspect of this right is a right to health care. The obligations this fact can and should impose upon Canada are contested. The international right to health care clearly requires some commitment to the provision of health care, but it can be difficult to identify what the content of this right should be. On the one hand, a right to all health care risks bankrupting those duty-bound to fulfill it. On the other hand, a narrow scope for the right risks

---

34 Flood, “Conclusion”, supra note 4 at 451. As discussed at 129, below, the reason-giving requirements that mark Canada’s commitment to transparency have been substantially constrained in the last decade. This does not change the fact that Canada is committed to the foundational norms of administrative justice, including transparency.

35 This norm is foundational for human rights legislation in every province and implied by the constitutional protection of equality in the Canadian Charter of Rights and Freedoms, s 15, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter].

36 International Convention on the Elimination of All Forms of Racial Discrimination, 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) is just one of several examples.

37 The most famous example is ICESCR, supra note 23, art 12, which recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Similar language appears in several documents.

38 Indeed, Colombia’s domestic right to health care, restricted to a “minimum level of subsistence,” arguably crippled their government: Alicia Ely Yamin, Oscar Parra-Vera & Camila Gianella, “Colombia: Judicial Protection of the
making it contentless. These are serious concerns for the substantive component of the right. There should, however, at least be a procedural dimension to the right. A right to a fairly administered system for identifying the content of the right in a given context arguably falls outside of international human rights law’s aforementioned commitment to non-discrimination in decision making.\(^{39}\) What “fairness” means here is contested. International human rights law does not provide an adequate metric for fulfilling this procedural dimension of international rights. I believe that Daniels and Sabin provide one of the better articulations of fairness and it can supplement the international framework that is already consistent with Daniels and Sabin’s basic demands.

Of course, AFR may not perfectly mirror international norms and the fact of reasonable pluralism that grounds the framework may be unique to liberal societies, but, as Daniels and Sabin also note, limit setting is required in states with varying socioeconomic systems and health care delivery designs.\(^{40}\) Where this problem is universal and international norms require procedural fairness, AFR’s attempt to solve the problem for liberal societies by ensuring procedural justice may provide guidance in any context. I argue that there is also some substantive content to the right to health care elsewhere,\(^{41}\) but the AFR framework can provide useful measures of the extent to which Canada’s health care system meets the procedural demands that arguably form part of the international right.

Given the reasons for applying AFR to the Canadian health care system, it is unsurprising that there is some work on this topic already. Some of this work even appears in Daniels and Sabin’s limited transnational analysis of

---

39 The commitment to non-discrimination is common throughout international human rights law. For instance, the ICESCR’s references to “equal and inalienable rights of all” and the rights of “everyone” (supra note 23, Preamble) are read as entailing equality and non-discrimination: Committee on Economic, Social and Cultural Rights, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, UNESCOR, 42nd Sess, UN Doc E/C.12/GC/20 (2009) at para 3.

40 Daniels & Sabin, Setting Limits, supra note 1 at vii.

41 See e.g. Da Silva, supra note 2.
health care systems’ AFR bona fides. The existing literature provides a baseline for further analysis of the extent to which Canada comports with Daniels and Sabin’s account of procedural justice in health care decision making. I am open to the possibility that other accounts of procedural justice may be equally applicable to the Canadian health care system so long as they can account for the demands of reasonable pluralism, administrative justice, and international human rights law. Yet the existing literature’s provision of a baseline for comparison provides a practical reason to conduct further study on Canada’s responsiveness to AFR norms where AFR is equally capable of accounting for reasonable pluralism, administrative justice, and international human rights law norms.

In this article, I update and expand upon the earlier research. To understand this broader analysis, however, one must first know some basic background information on the structure of the Canadian health care system. I provide it in the next Part.

### III. The Canadian Health Care System: An Overview

The basic features of the Canadian health care system will likely be familiar to most readers of this text, so I will minimize the details here. I raise other points as necessary for the AFR analysis below. In Canada, health care is an area of “concurrent jurisdiction” between the federal government and the provincial governments. “Health” and “health care” are not explicitly placed under the purview of either level of government in the original constitutional division of powers. Provisonal authority over hospitals, guaranteed in Section 92 of the Constitution, and a federal spending power which is not explicitly mentioned in the text of the Constitution, but is instead “inferred” from a variety of other enumerated powers, provide

---

42 Daniels & Sabin, Setting Limits, supra note 1 at 180–84.

43 See e.g. Carter v Canada (AG), 2015 SCC 5 at para 53, [2015] 1 SCR 331 [Carter].

44 Constitution Act, 1867 (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No 5, ss 91–92 [1867]. For further support for this interpretation, see Martha Jackman, “Constitutional Jurisdiction over Health in Canada” (2000) 8 Health LJ 95 at 110.

45 1867, supra note 44, s 92(7).

46 Jackman, supra note 44 at 97.
the concurrent jurisdiction required to establish the joint federal-provincial health care provision collaboration that frames the mainstream Canadian health care system.

This collaboration is primarily established by perhaps the most important example of federal action in the health care domain: the *Canada Health Act (CHA)*. The *CHA*, and the provincial and territorial statutes that operationalize it, are the primary legal foundations for Medicare, the “institutional core of Canada’s health care system.” It sits at the centre of the mainstream Canadian health care system and the legal regulation thereof. It gives the federal government the power to transfer funds to the provinces for health care provision through provincial insurance regimes. To receive federal funding under the *CHA*, provinces must meet a variety of requirements, including the provision of certain “hospital services” and “physician services” (though provision and/or insured coverage of non-hospital dental services, prescriptions, and some other goods are specifically not required). The definitions of these terms provide limits on the provinces’ discretion on what services they insure. For the purposes of the *CHA*:

“*hospital services*” means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability…

“*physician services*” means any medically required services rendered by medical practitioners[…]

To receive funding, then, the provinces must insure “medically necessary” or “medically required” services. This suggests that necessity and requirement are reasons provinces ought to consider when making distributive decisions. Yet “medically necessary” and “medically required” are undefined, leaving latitude on what to cover. Each province then has its own health insurance act, which spells out who gets to decide what “necessary” or “required”

---

47 RSC 1985, c C-6 [*CHA*]. Jackman describes it as “a classic exercise of the federal spending power” (*supra* note 44 at 98).


49 *CHA, supra* note 47, ss 2, 5, 7–12.

goods are insured in their respective health care systems. These decisions must be reasonable to comport with general administrative law principles and must not discriminate in their intent or effect as a matter of both constitutional law and human rights law, but the provinces can reach vastly different substantive outcomes in their decisions on what to cover. Provincial discretion on how to define “medically necessary” and “medically required” can even allow some World Health Organization (WHO)-identified essential medicines to go uncovered throughout a province.\textsuperscript{51} Insulin is just one example of an essential medicine that “is not consistently funded” across the country.\textsuperscript{52} Provincial discretion on where to cover services further limits coverage. The CHA only requires funding for medically necessary hospital services and medically required physician services. Provinces retain the discretion to not cover necessary or required services outside of the hospital or direct physician care.\textsuperscript{53} Several WHO-identified essential medicines are commonly offered as prescription (e.g., lorazepam\textsuperscript{54}) or over-the-counter (ibuprofen\textsuperscript{55}) medicines.\textsuperscript{56} Coverage of these goods is inconsistent. Funding for prescription drugs “varies from province to province.”\textsuperscript{57} Most over-the-counter drugs are not covered at all. Some provinces provide supplemental government prescription drug insurance.\textsuperscript{58} Yet “access to prescription drugs


\textsuperscript{52} Flood, “Conclusion”, \textit{supra} note 4 at 449.

\textsuperscript{53} See e.g. Ontario’s key provision on insured services which states that services are insured “only if they are provided in or by designated hospitals or health facilities” and “provided to insured persons in prescribed age groups” (\textit{Health Insurance Act}, RSO 1990, c H.6, ss 11.2(3)–(4) [\textit{HIA}, \textit{ON}]).

\textsuperscript{54} WHO, \textit{Essential Medicines}, \textit{supra} note 51 at 5.

\textsuperscript{55} \textit{Ibid} at 18.

\textsuperscript{56} One may debate whether certain over-the-counter items, like condoms, listed in WHO, \textit{Essential Medicines}, \textit{ibid} at 34, even constitute medicines, but a wide variety of prescription and over-the-counter WHO-identified essential goods are clearly medicinal.

\textsuperscript{57} Lahey, \textit{supra} note 48 at 18.

continues to depend on private means for many Canadians.”

Essential goods may not even be covered in hospitals and physicians’ care and no goods must be covered outside those contexts. Serious gaps in Medicare coverage and inconsistencies in coverage across the provinces result.

There are also a variety of federal health care programs for specific groups. The programs constitute health care sub-systems that combine with Medicare to form the Canadian health care “system.” The Constitution grants the federal government authority over, and responsibility for, “Militia, Military and Naval Service, and Defence,”

“The Establishment, Maintenance, and Management of Penitentiaries,”

“Indians, and Lands reserved for the Indians,” and “Naturalization and Aliens.”

The federal government exercises its consequent powers over the military, federal prisons, Aboriginals, and immigrants in the health care setting. While the provinces maintain jurisdiction over health care provision for most of these groups,

the federal government’s spending power and powers over specific groups and locations justify several federal government health programs. Correctional Service Canada provides health care services to federal prisoners.

Veterans Affairs Canada provides health care benefits to some members of the armed forces and veterans. In both cases, the programs

59 Lahey, supra note 48 at 7. Coverage is better for certain populations, like senior citizens, in some jurisdictions, but this too varies from province to province.

60 1867, supra note 44, s 91(7).

61 Ibid, s 91(28).


63 1867, supra note 44, s 91(25).

64 Many immigrants, most Aboriginals, and all veterans are thus covered by Medicare. Some provinces even historically provided health care to refugee claimants but ceased doing so in the 1990s. See Canadian Doctors for Refugee Care v Canada (AG), 2014 FC 651 at para 40, [2015] 2 FCR 267 [Refugee Care].


66 See e.g. Veterans Affairs Canada, “Health Care Benefits (Treatment Benefits)”, online: <www.veterans.gc.ca/eng/services/health/treatment-benefits> and its associated links for details.
fill gaps in Medicare coverage since Canadian Forces members and federal prisoners are barred from \textit{CHA} coverage.\footnote{CHA, \textit{supra} note 47, s 2.} Citizenship and Immigration Canada likewise fills a gap in coverage by providing health care services to refugees, refugee claimants, and other new immigrants “seeking the protection of Canada” through, for instance, the IFHP.\footnote{The phrase “individuals ‘seeking the protection of Canada’” is used as a catch-all for refugees, refugee claimants, failed refugee claimants, positive Pre-Removal Risk Assessment recipients, victims of human trafficking, persons granted permanent residency for policy or humanitarian reasons, or immigration detainees in \textit{Refugee Care, supra} note 64 at paras 58–60. I adopt that phrasing here when referring to all IFHP claimants.} The federal government also funds health care services on First Nations reserves and provides on-reserve services in some remote regions.\footnote{Health Canada, “Fact Sheet – First Nations and Inuit Health Branch” (2008), online: <www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgsni/fact-fiche-eng.php> [HC, “Fact Sheet”]. For a broader list of Aboriginal health-related services funded by Aboriginal Affairs and Northern Development Canada or Health Canada, see The Jordan’s Principle Working Group, \textit{Without Denial, Denial, Delay, or Disruption: Ensuring First Nations Children’s Access to Equitable Services through Jordan’s Principle} (Ottawa: Assembly of First Nations, 2015) at 62. The federal government can also “authorize the use of [reserve] lands” for “Indian health projects” by virtue of the \textit{Indian Act}, RSC 1985, c I-5, s 18(2). Section 73 of the \textit{Indian Act} grants further authority to create regulations “to provide medical treatment and health services for Indians” (\textit{ibid}, s 73(1)(g)).” Per section 81, band council regulations must be consistent with those federal regulations (\textit{ibid}, s 81(1)(a)).} The First Nations and Inuit Health Branch of Health Canada then supplements Medicare through the NIHBP by providing health care services that are not insured by provincial insurance programs to both First Nations and Inuit (but not to Métis).\footnote{MacIntosh, \textit{supra} note 5 at 605; Health Canada, \textit{Non-Insured Health Benefits Program: Annual Report 2014/2015}, by the First Nations and Inuit Branch (Ottawa: Health Canada, 2016) at 3 \textit{[Annual Report 2014/2015]}. Whether the recent recognition of Métis as “Indians” for constitutional purposes in \textit{Daniels, supra} note 62 will change anything about Métis NIHBP coverage remains to be seen.} The scope of the federal government’s responsibilities to these groups is contested. As Constance MacIntosh notes, “whether Canada has legal discretion to not address the health care needs of Indigenous peoples” is a
live question.\textsuperscript{71} Some Aboriginals can access a wider variety of goods and services using government funds than their non-Aboriginal counterparts (including pharmacy benefits and dental services) through the NIHBP.\textsuperscript{72} Yet controversy over the nature of this program persists. As MacIntosh notes, “[i]n contrast to Canada’s position that N\textsuperscript{I}HB[P] is a discretionary policy-driven initiative, Indigenous organizations characterize the N\textsuperscript{I}HB[P] … as a manifestation of Canada’s lawful obligations to Indigenous Canadians emanating from treaty rights and the federal fiduciary obligation.”\textsuperscript{73} Other federal programs, such as the refugee-focused IFHP, face similar controversies.\textsuperscript{74} Yet the federal government clearly believes it has the authority, if not the responsibility, to provide health care to the aforementioned groups.

Previous scholarship on Canada’s compliance with the AFR framework focused on Medicare. This work expands on that analysis by focusing on some of the additional federal programs and analyzing how they contribute to Canada’s compliance. I will focus on the IFHP and NIHBP. I take this focus due to the deep vulnerability of refugees, other immigrants seeking the protection of Canada, and Aboriginal Canadians, as well as the legal obligations Canada owes to these groups. The history of colonialism and forced migration, and continuing inequities between Aboriginals and other Canadians in economic and health outcomes, render many Aboriginals vulnerable. Refugees, in turn, are vulnerable by definition. Refugees and others seeking the protection of Canada were also forced to migrate. They come to Canada with no guarantee of legal status and often lack social and economic goods required to thrive here if they do attain legal status. Studying the IFHP and the NIHBP thus serves as a good proxy for Canada’s commitment to vulnerable populations, which is also required by international human rights law.\textsuperscript{75}

\textsuperscript{71} MacIntosh, \textit{supra} note 5 at 576.

\textsuperscript{72} See e.g. \textit{ibid} at 605.

\textsuperscript{73} \textit{Ibid} at 608.

\textsuperscript{74} The extent of the government’s duties to persons under that program and whether the government can remove groups from coverage was, for instance, a central issue in \textit{Refugee Care, supra} note 64. The issue of who must be covered by a program if it exists is clearly different from the issue of whether government must create a program. Yet both issues relate to the question of whether governments owe duties to provide programs to specific persons.

\textsuperscript{75} Relevant international human rights law documents here include \textit{Convention on the Elimination of All Forms of Discrimination against Women}, 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981); \textit{Convention
Canada also owes duties to both groups. The federal government may owe duties to Aboriginals and refugees as a correlative of their constitutional powers. At minimum, the Constitution clearly entrenches Aboriginal treaty rights, and in some cases, those treaty rights may include certain health care provision entitlements. The government’s fiduciary relationship with Aboriginal Canadians is well-established; fulfilling that fiduciary relationship arguably requires the provision of health care. Canada owes duties to both Aboriginals and refugees under international law. Of course, similar arguments can also be used to justify focusing on armed forces, veterans, federal prisoners, and perhaps even other classes of immigrants. Federal prisoners are also vulnerable. Other immigrants can also be vulnerable.

---


77 MacIntosh, supra note 5 at 589–92.

78 Ibid at 576, 592–96.


80 There is, moreover, overlap between federal prisoners and the other groups. Aboriginal representation in prisons is notoriously high. The United Nations Human Rights Committee took issue with this state of affairs in 2015: Human Rights Committee, Concluding Observations on the Sixth Periodic Report of Canada, UNHCROR, 114th Sess, UN Doc CCPR/C/CAN/CO/6 (2015) at para 18. Members of the armed forces and veterans face important health care concerns and can be rendered vulnerable by battle-related health concerns, such as post-traumatic stress disorder, but it is difficult to make the case that a member
when, for instance, their immigration status is tied to precarious work situations.\textsuperscript{81} Canada owes duties to all three groups. Yet I can only examine a limited number of programs in any real depth in a limited space.

The basic features of the IFHP are clear, but the program is, at best, only barely out of a period of transition. The IFHP is, fundamentally, a supplementary program that funds health care services for refugees and others seeking the protection of Canada who do not (yet) qualify for Medicare.\textsuperscript{82} While successful refugee claimants secure eligibility for provincial health insurance, other claimants do not. Those uninsured by the provinces include refugees who have applied for refugee status but whose claims have not been heard; refugee applicants whose claim has been denied and are awaiting return to their country of origin; and – a variation on the latter theme – refugees whose claims have been denied but cannot be deported because their countries of origin are deemed insufficiently safe.\textsuperscript{83} The IFHP is meant to fill this gap. Traditionally, the federal government chose which goods it would fund and set criteria for eligibility to receive them. The IFHP was originally intended to only provide emergency and essential health care.\textsuperscript{84}

Pre-2012 coverage for all qualified claimants was “comparable to that which

\textsuperscript{81} For some issues with temporary worker programs, see e.g. Law Commission of Ontario, \textit{Vulnerable Workers and Precarious Work} (Toronto: LCO, December 2012). Live-in caregivers who work in Canada for two years as part of the unique temporary foreign worker program should qualify for residency status yet they face lengthy delays in their applications, even after government promises to limit the backlog. See Nicholas Keung, “Foreign Caregivers Face Lengthy Wait for Permanent Status”, \textit{The Toronto Star} (21 July 2015), online: <www.thestar.com/news/immigration/2015/07/21/foreign-caregivers-face-lengthy-wait-for-permanent-status.html>. Students and temporary workers can fall under different health care coverage regimes beyond the scope of this work.

\textsuperscript{82} The IFHP predated Medicare (\textit{Refugee Care, supra} note 64 at paras 35–38), but now plays this supplementary role.

\textsuperscript{83} The process for determining refugee status appears in \textit{Immigration and Refugee Protection Act}, SC 2001, c 27 and its attendant regulations.

\textsuperscript{84} See Lisa A Merry et al, “Refugee Claimant Women and Barriers to Health and Social Services Post-Birth” (2011) 102:4 Can J Public Health 286 at 286.
Canadians receive through provincial health care plans\textsuperscript{85} and even covered some prescriptions, dental care, and psychological services that are not generally covered by Medicare.\textsuperscript{86}

In 2012, the federal government attempted to restructure the IFHP and introduced different tiers of coverage,\textsuperscript{87} beginning an ongoing period of transition. “Refugee claimants from non-[Designated Countries of Origin (DCOs)], refugees, successful [Pre-Removal Risk Assessment (PPRA)] applicants, most privately-sponsored refugees,” and pre-2012 claimants received “Health Care Coverage,” a tier that was supposed to be similar to Medicare and subject to the same gaps in essential coverage; yet they faced the further constraint that such services were only available if they were also “of an urgent or essential nature.”\textsuperscript{88} “[M]ost government-assisted refugees and some privately-sponsored refugees, as well as victims of human trafficking and some individuals admitted under a public policy or on humanitarian and compassionate grounds” received “Expanded Health Care Coverage,” which was designed to fulfill further essential needs, including “translation services for health purposes,” “laboratory, diagnostic and ambulance services,” and “supplemental” services and products.\textsuperscript{89} Persons from DCOs, such as Afghanistan, the war-torn state where Canadian Forces were recently deployed, were placed in a lower tier that only received the goods necessary to avoid a public health and safety emergency.\textsuperscript{90} PPRA claimants were effectively removed from coverage. The restructuring changed how the program operated during the period that the changes were in force. Some studies suggest that patients, health care providers, and even


\textsuperscript{86} Ibid. The IFHP explicitly provided coverage for “prenatal, contraception and obstetrical care; essential prescription medications; emergency dental treatments; and treatment and prevention of serious medical conditions” and other services were available with prior approval. See Merry et al, supra note 84 at 286.


\textsuperscript{88} Ibid, s 1; Refugee Care, supra note 64 at paras 61–79.

\textsuperscript{89} Refugee Care, supra note 64 at paras 67–68

\textsuperscript{90} Order Respecting the IFHP, supra note 87, ss 1, 4(3).
the IFHP’s insurance provider lacked clarity on what was covered, leading health care providers to refuse care or charge fees and insurers to deny meritorious claims. Yet, in a decision on the constitutional challenge to the restructuring, the Federal Court (FC) found that the cuts in coverage violated the Section 12 Canadian Charter of Rights and Freedoms right to be free from cruel and unusual treatment by “set[ting] out to make the lives of disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here” and, as a consequence, also “potentially [jeopardizing] the health, and indeed the very lives, of … innocent and vulnerable children.” The court also held that limiting the coverage of claimants from DCOs to services required for “Public Health or Public Safety” (PHPS) violated the Section 15 Charter right to equality and freedom from discrimination on the basis of national origin by risking the lives of those claimants and perpetuating the stereotype that they were “cheats.” Neither rights violation could be justified in a free and democratic society, so Orders in Council instituting the changes were deemed to be of no force and effect.

The federal government must operate within the structure of the Orders in Council creating the IFHP, but it can make changes to the Orders in Council and its related regulations, including changes in coverage, with relative ease. It does not owe a duty of procedural fairness to the public

---

91 Merry et al, supra note 84 at 288–89; Steve Barnes, “The Real Cost of Cutting the Interim Federal Health Program”, (Toronto: Wellesley Institute, 2013) at 6. The Federal Court heard similar testimony, including reports that the administrative problems led to doctors requesting up-front payments from or refusing services to people who are qualified for particular services: Refugee Care, supra note 64 at paras 133–41.

92 Charter, supra note 35, s 12; Refugee Care, supra note 64 at paras 689–91. Notably, some provinces expanded their insurance coverage for some immigrants or created new temporary coverage in the time between the Order in Council and the Federal Court decisions. See ibid at paras 257–63.

93 Charter, supra note 35, s 15; Refugee Care, supra note 64 at paras 849–51.

94 Refugee Care, supra note 15; Refugee Care, supra note 64 at para 1075.

95 Ibid at para 1116.

96 Ibid at para 52.
or any other relevant stakeholders before making changes;\textsuperscript{97} there is, accordingly, no duty of consultation prior to decision making. The responses to the FC decision – specifically the changes to tiered coverage immediately after the decision and later restoration of the program to something resembling pre-2012 levels – exemplify that these changes can be made with relative speed and that this speed can maintain the threat of retrogression. They also highlight the fact that the IFHP’s transition period is either ongoing or only recently ended. The FC decision limits the discretion of the federal government over who and what to cover under the IFHP, but the federal government initially did not respond to the FC decision by reinstating the pre-2012 system. It maintained its tiered system of coverage. Top-level claimants in the 2015–2016 IFHP received essential goods available under Medicare, as well as supplemental and prescription coverage. Supplemental coverage provided funding for limited dental care, vision care, and psychological services.\textsuperscript{98} Prescription drug coverage funded some medication that the WHO classifies as essential, but that Medicare does not cover outside of the hospital and physician services contexts, such as acetaminophen.\textsuperscript{99} It did not fill all the gaps in Medicare coverage. Provincial Medicare formularies are (even now) largely used to set prescription drug coverage standards; the NIHB formularies operate in the territories, but only 44 goods appear on the insurance provider’s “IFHP Additional Drug Benefits” list.\textsuperscript{100} Until recently, claimants enrolled in lower levels of the IFHP received even less coverage. After the election of a new, Liberal federal government in 2015, the federal government decided not to continue legal proceedings concerning the 2012 cuts and restored the IFHP to pre-2012 levels. Coverage for all eligible persons was restored to pre-2012 levels in April 2016. Groups of claimants are now differentiated by the length, rather than the content,

\textsuperscript{97} See e.g. \textit{ibid} at para 440.


\textsuperscript{99} WHO, \textit{Essential Medicines, supra} note 51 at 2 (referred to in the Model List of Essential Medicines as “paracetamol”).

\textsuperscript{100} Blue Cross, “Benefit Structure Information” (2015), online: <www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187212198708&blobheader=application%2Fpdf>. 
of their coverage. Yet the threat of tiered coverage still remains. It was initially unclear whether the Liberal commitment to restore funding to the program would be joined by a decision to end tiered coverage. There is a nearby possible world where a new legal challenge to tiered coverage would be feasible. Continuing legal battles over the 2012 proposals and/or new legal battles over a different Liberal policy could have produced further changes to the IFHP. It is, in other words, legally easy to change IFHP coverage, but this ease can lead to retrogression and final determinations on the constitutionality of such changes by an apex court are still lacking.

The NIHBP, in turn, supplements provincial Medicare programs and federally-funded on-reserve services by insuring prescription and over-the-counter drugs, dental and vision care, “short-term crisis intervention mental health counselling,” medical supplies and equipment, and medically-related transportation costs for members of registered First Nations and Inuit groups. It provides this coverage as matter of last resort. If the goods are not otherwise covered by private health insurance, provincial plans, or other public programs, the NIHBP funds goods that Canadians outside the program would need to pay for out-of-pocket. As with Medicare and the IFHP, the NIHBP reimburses health care professionals for their services and patients are supposed to receive NIHBP-covered services for free at the point of service. The NIHBP’s annual reports list criteria for the selection of the goods it will cover. Every quarter, the program updates the list of drugs deemed necessary for the purposes of the NIHBP. A 2016 version


102 See e.g. Annual Report 2014/2015, supra note 70 at 3; Health Canada, “Non-Insured Health Benefits for First Nations and Inuit” (2015), online: <www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php>. For the First Nations registration process, see Indian Act, supra note 69. While that act does not apply to Inuit or Métis, both are subject to similar registration processes.

103 Annual Report 2014/2015, supra note 70 at 3.

includes, but is not limited to, antihistamines,\textsuperscript{105} contraceptives,\textsuperscript{106} gastrointestinal drugs,\textsuperscript{107} hormones,\textsuperscript{108} vitamins,\textsuperscript{109} traditional “over-the-counter” drugs like the allergy medications Reactine and Claritin,\textsuperscript{110} 33 antiretrovirals that are not covered by Medicare (five of which are only available to HIV patients and require prior approval),\textsuperscript{111} antidepressants,\textsuperscript{112} and antipsychotics.\textsuperscript{113} The NIHBP explicitly excludes “anti-obesity drugs, household products, cosmetics, hair growth stimulants, and megavitamins.”\textsuperscript{114} People whose eligibility claims have been denied and those who seek to add goods to the list covered by the program face three levels of inter-departmental administrative appeal before judicial review of their challenges.\textsuperscript{115} Disputes over “excluded goods” cannot be appealed.\textsuperscript{116}

\textsuperscript{105} DBL 2016, supra note 104 at 1.

\textsuperscript{106} Ibid at 99.

\textsuperscript{107} Ibid at 113.

\textsuperscript{108} Ibid at 123.

\textsuperscript{109} Ibid at 145.

\textsuperscript{110} Ibid at 1.

\textsuperscript{111} Ibid at 10–12.

\textsuperscript{112} Ibid at 76–82.

\textsuperscript{113} Ibid at 83–90.


\textsuperscript{115} An inter-departmental challenge begins with the Manager of the Pharmacy Policy Development Division or the Dental Policy Unit, before moving on to the Director, Benefit Management and Review Services Division, and ending with the Program’s Director General. See Government of Canada, “Appealing a Decision under the Non-Insured Health Benefits Program” (2016), online: <www.healthycanadians.gc.ca/health-system-systeme-sante/services/non-insured-health-benefits-services-sante-non-assures/appealing-decision-faire-appel/index-eng.php>.

\textsuperscript{116} DBL 2016, supra note 104 at viii.
These broad structural features of the Canadian health care system do not tell the whole story of Canadian health care coverage and delivery or the legal regulation thereof. They do not, for instance, account for the complexities of the workers’ compensation regime. The facts above nonetheless provide basic background necessary for analyzing the details of the system that are relevant to the AFR framework. It is now prudent to frame these details in light of the substantive demands of the AFR framework. As made clear in the following Part, Canada lacks (A) and it is difficult to determine the extent to which it fulfills (B). Canada thus clearly lacks (D) in all but the minimal sense of having a health care system that is legally regulated. I accordingly only focus on the extent to which Canada provides (A)–(C). I begin with (A).

IV. The Transparency Requirement: Reason-Giving in the Canadian Health Care System

In earlier work on this topic, Flood stated that Canada’s Medicare regime does not follow the AFR framework.117 Yet following the framework need not be an all-or-nothing affair. The legal system regulating Canada’s health care system arguably does feature some of the structural features required by AFR. Canada’s compliance with the AFR framework also appears to be improving, though it remains far from perfect. For instance, when Flood was doing her work, the provision of reasons was not one of the structural features provided by the Canadian health care system. Some headway has since been made in the public provision of reasons for health care coverage decisions. Yet, as discussed throughout this text, work remains to be done if Daniels and Sabin’s call for AFR compliance is to be fully heeded.

The problems here are clear. The reasons for decisions on what health care goods are covered in a given province are generally not publicly available. The committees charged with deciding what is covered under our health insurance regimes tend not to be explicitly required to provide reasons for their decisions, let alone make them public. For instance, Ontario legislation establishes rules for the composition of the Physician Services Committee, but does not indicate that the Committee needs to provide reasons for their actions under the legislation.118 The only clear exception is that denial of particular claims for coverage by the General Manager of the

117 Flood, “Conclusion”, supra note 4 at 452.
118 HIA, ON, supra note 53, s 5.1.
health insurance regime must be reported to the Ministry of Health and the report must include an account of the grounds for that decision; these decisions do not explicitly need to be made public.\textsuperscript{119} Even if one thinks that requiring reasons for every coverage decision on an item-by-item basis is too demanding, a system that fails to provide general reasons for decisions fails any reasonable reason-provision standard.

Even administrative appeal bodies are not always required to provide reasons for their decisions. There is a general rule of administrative law, dating back to the Supreme Court of Canada (SCC)’s decision in \textit{Roncarelli v Duplessis} that administrative decisions cannot be arbitrary.\textsuperscript{120} This arguably entails that at least some public decisions must be \textit{based on reasons}. The circumstances in which these reasons must be made publicly available, however, are more limited. In \textit{Baker v Canada (Minister of Citizenship and Immigration)} (\textit{Baker}), the SCC famously stated that “in certain circumstances, the duty of procedural fairness will require the provision of a written explanation for a decision.”\textsuperscript{121} If one takes Daniels and Sabin’s claims about the status of health care as a public good in the domain of distributive justice (namely, Premises 1 to 5 and the Conclusion above) seriously, the health insurance coverage context is arguably a context where the provision of written reasons for decisions ought to be required. It is thus heartening that the body charged with hearing appeals in Ontario, the Health Services Appeal and Review Board (HSARB), provides written reasons in several cases despite not being explicitly required to do so. Yet the fact that health care-related tribunals should provide reasons has not led Canadian courts to require those tribunals to do so. The circumstances addressed in \textit{Baker} are limited and subsequent case law suggests that the requirement to give reasons may be exceptional rather than a wide-ranging duty for many Canadian tribunals, creating a distinction between the requirements of Canadian administrative law and Daniels and Sabin’s framework.\textsuperscript{122}

\textsuperscript{119} \textit{Ibid}, s 25.

\textsuperscript{120} [1959] SCR 121 at 140–42, 16 DLR (2d) 689.

\textsuperscript{121} [1999] 2 SCR 817 at 848, 174 DLR (4th) 193.

\textsuperscript{122} For an overview of the case law in which courts recognized and extended their own ability to supplement or introduce administrative reasoning where administrative decisions do not provide their own reasons, see Paul A Warchuk, “The Role of Administrative Reasons in Judicial Review: Adequacy & Reasonableness” (2016) 29 Can J Admin L & Prac 87 at 89–95.
In addition, impediments to the public display of appeal boards’ reasons may remain after reason-giving conditions obtain. For instance, Flood and Michelle Zimmerman’s work on the HSARB raises two potential problems: “The Boards’ judgments are not online and appointments must be made to view the judgments archived in Toronto. Furthermore, because the judgments are not indexed, in order to locate a decision one needs to know the name and year of the case.” There may be impediments to accessing the written reasons for appeal decisions. Where access to these written decisions can be an indirect method for accessing reasons for administrative decisions, these may also be impediments to accessing the reasons for first instance decision making that are necessary for appeals.

Recent developments in the public display of appeal decisions suggest that Canada is making some strides in providing public reasons. Getting reasons from the initial decision makers in Ontario remains difficult, but access to the decisions of the aforementioned HSARB is improving. HSARB decisions are now indexed on the Canadian Legal Information Institute website, an online non-profit managed by the Federation of Law Societies of Canada. Initial indexing took place in 2010 and digitization of the backlog of decisions continues; one HSARB case dating back to 2002 was on the website by 22 January 2015 (though no further 2002 cases were added in the following year). The site, which includes a search option, is also kept relatively up-to-date. Two 2015 decisions, one on a hearing request and one substantive decision on a November 2014 hearing, appeared within the first three weeks of the year. A later check-in on the timeliness of the posting of decisions, performed on 10 June 2016, unearthed two June 2016 decisions including a decision from a 3 June 2016 written hearing. Quebec’s main administrative tribunal, the Tribunal administratif du Québec (Administrative Tribunal of Québec), which is the site of first instance for insurance decision appeals, similarly maintains an online database of its decisions.

---

123 Flood & Zimmerman, supra note 4 at 35.
124 VR v Ontario (Health Insurance Plan), 2002 CanLII 61089 (Ont HSARB).
125 RS v Chirico, 2015 CanLII 334 (Ont HSARB).
126 MS v Ontario (Health Insurance Plan), 2015 CanLII 1390 (Ont HSARB).
127 SH v Central East Community Care Access Centre, 2016 CanLII 33704 (Ont HSARB); MT v Mississauga Halton Community Care Access Centre, 2016 CanLII 32347 (Ont HSARB).
128 La Société québécoise d’information juridique, “Trouver une décision”, on-
While accessing the reasons for decisions about which services are covered remains difficult, a systematic review of accessible appeal decisions could provide some insight about which reasons decision makers rely on to decide what is covered under the health insurance regimes in at least two provinces. This indirect method falls short of the reason-giving requirement envisioned by Daniels and Sabin, which requires that the reasons for decisions create something analogous to case law. However, it does constitute progress made since Flood et al wrote about the applicability of the AFR framework to the Canadian health care system.

Even where administrative appeal reasons are (or even must be) made public, appeals are an inefficient way to access reasons that ought to be provided as a matter of procedural justice prior to requesting a review. Human rights law tribunals have a history of long wait times. Ontario accordingly recently overhauled its human rights mechanisms to ensure greater accessibility. Where a further judicial review is required to get reasons, this problem is even more pressing. The judicial review process can be time-consuming. In a recent decision, the SCC acknowledged that wait times for decisions in criminal cases have reached unacceptable lengths. These delays, in turn, cause delays in civil and judicial review proceedings. Wait times remain long in all three contexts, creating frequent fodder for newspaper articles. General administrative law procedures can at least be less time-consuming. While waiting for a hearing may still prove onerous, some of these bodies take less time to provide reasons. For instance, while Ontario’s appeal body for health care insurance decisions takes three months to provide written reasons, Alberta’s equivalent body, the Appeal Panel, which has a more limited jurisdiction, is required to provide reasons within five

---

129 Daniels & Sabin, “Limits”, supra note 3 at 327–28. Going to case law to get those reasons in the first place seems to get things backwards.


131 R v Jordan, 2016 SCC 27, 398 DLR (4th) 381. In the case at issue, the accused had waited two and a half years for the completion of the preliminary inquiry from the moment he was charged: ibid at para 9.
...days of the hearing. Yet, even then, these procedures are an inefficient way to access reasons one should have as a matter of procedural justice and judicial review may be required to gain substantive outcomes.

The IFHP has arguably greater issues of transparency beyond those discussed above. The IFHP not only makes its decisions without adequate public consultation, but also fails to publish the reasons for its decisions. For instance, beyond the suggestion that pharmaceutical drugs at the lowest level of coverage are only available where they are necessary to “prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern,” the Summary of Benefits that listed the different levels of coverage in the post-FC decision interim program did not explain why the different levels existed or why particular groups of claimants fit into different levels of coverage. The opacity of reasons for coverage is sometimes mirrored by opacity with regard to what goods are covered. When the federal government tried to implement the aforementioned budgetary cuts in 2012, doctors were unclear on which goods were still covered following the changes. The government is transparent about its reasons for implementing the program. The stated purpose of the program is to provide “short term, interim medical care.” Yet this is, at best, a severely limited guide to understanding the reasons for why certain goods are covered. The stated purpose explains why certain long-term health interventions are not covered by the program. It does not explain how the government decides whether a particular good that can be provided on a short-term or interim basis is covered under the program. It also does not explain why certain long-term goods (like eyeglasses) were covered in higher tiers of the post-decision program or why different levels of coverage existed in the first place.

The federal government was transparent in its reasons for proposing changes to the program. It listed four reasons in its response to the aforementioned constitutional challenge to the government’s attempted re-structuring of the IFHP: (i) cost containment, (ii) public health and safety, (iii) the “integrity of Canada’s refugee determination system and [deterrence

132 Pitfield & Flood, supra note 4 at 493–94.
134 Refugee Care, supra note 64 at paras 133–41.
135 Ibid at para 50.
of its abuse,” and (iv) “fairness to Canadians,” which can be interpreted as a catch-all for the concern that immigrants receive greater coverage than Canadians receive under Medicare.136 Yet this transparency did not save the proposed cuts. The FC found that (iv) was not a “pressing and substantial” objective in “the absence of any evidence that the pre-2012 IFHP was unfair to Canadians or that the 2012 IFHP is any fairer to Canadians,” that the proposed changes were not rationally connected to (ii) or (iv), and finally, that the proposed cuts failed the minimal impairment and proportionality tests on any of the four objectives.137 This example highlights the limits and potential value of transparency for health care justice in Canada. As the case, entitled Canadian Doctors for Refugee Care v Canada (AG), makes clear, transparency cannot save a law or policy that conflicts with substantive Canadian law. The proposed cuts to the IFHP were inconsistent with substantive Charter provisions.138 Where the reasons for infringing rights are unjustified, publicizing the reasons for violating those rights changes very little in terms of the outcome of a Charter challenge. However, this reason-giving still makes a small contribution to accountability for reasonableness and it may even advance health care justice broadly. Governmental transparency in this case made the inadequacy of the reasons for the decision clear, and thereby contributed to the long process of restoring the program to its previous non-tiered status. Yet full transparency in the IFHP is clearly lacking.

The NIHBP, by contrast, fares well on the transparency metric. The NIHBP’s annual reports list the types of goods that are covered, set out guiding principles for the program (including principles guiding the selection of goods to be included in coverage), and state how much is spent providing selected goods and services.139 While individuals must request the reports, I received copies within a week of requesting them, and summaries are available online. The 2014/2015 annual report includes examples of the guiding principles:

- Benefits will be provided based on professional, medical or dental judgment, consistent with the best practices of health services delivery and evidence-based standards of care;

136 See e.g. ibid at paras 53–56.

137 Ibid at paras 912–28, 938–1075.

138 Ibid at paras 1079–84.

139 See e.g. Annual Report 2014/2015, supra note 70 at 3, 27–70.
• There will be national consistency with respect to mandatory benefits, equitable access and portability of benefits and services;

• [And the NIHBP] will be managed in a sustainable and cost-effective manner.  

The NIHBP provides regular coverage updates online. Complete annual drug benefit lists are also available online without a request and they provide more fine-grained reasons for coverage than the general NIHBP annual reports. To give a recent example, the NIHBP, Collaborative Emergency Centers, and Drugs and Therapeutics Advisory Committee balanced several factors in making listing decisions about changes to the Drug Benefit List, such as:

• The needs of First Nations and Inuit clients;

• Accumulated scientific and clinical research on currently-listed drugs;

• Cost-benefit analysis;

• Availability of alternatives;

• Current health practices; and

• Policies and listings in provincial drug formularies.

The Drug Benefit List also explains the process for the removal of goods from the program, including reasons for removal. While the NIHBP does not explain each of its decisions about individual coverage, it does publish its decisions and the principles guiding its decision making.

---

140 Ibid at 3. These principles leave some room for professional discretion.


142 DBL 2016, supra note 104 at v.

143 It lists clear criteria for the removal of goods and further policies and rules: ibid at vi–xi.
Decision making in the Canadian health care system, then, largely continues to be opaque. The NIHBP offers a notable exception to this general principle. Its regular, scheduled dissemination of decisions and reasons for decisions offer an example of best practices for improving transparency in other parts of the Canadian health care system.

V. THE PUBLIC ACCEPTANCE/Acceptability REQUIREMENT: THE ADEQUACY OF REASONS FOR DECISIONS IN THE CANADIAN HEALTH CARE SYSTEM

There are two ways of understanding the second requirement of AFR. It is difficult to determine how Canada fares on either interpretation. On one articulation of this requirement, AFR requires that “the grounds for decisions must be ones that fair-minded people can agree are relevant to meeting health care needs fairly under reasonable resource constraints.”\(^\text{144}\) Elsewhere, however, the Relevancy Condition is formulated such that decisions must be based on “evidence, reasons, and principles that are accepted” by fair-minded people.\(^\text{145}\) Whether the reasons for decisions need to be accepted or merely acceptable is ambiguous. The lack of reason-giving in the Canadian health care system makes it difficult to determine whether the public accepts the reasons for health care decision making. If the public does not know why decisions are made, how can they decide whether they think those decisions were made for good reasons? Access to reasons seems to be a prerequisite for acceptance of reasons. The systematic review of all appeal decisions in Ontario and Québec suggested above could be helpful, but such a review is currently unavailable to the public and is beyond the scope of this article.

Direct evidence of how Canada fares is hard to identify if the acceptance of reasons understanding of this requirement is adopted. No public will ever accept all decisions made by a rationing body.\(^\text{146}\) It is thus unsurprising that there are persistent demands to expand coverage. Demands for increased drug benefits and/or long-term care coverage are particularly persistent and

\(^{144}\) Daniels & Sabin, Setting Limits, supra note 1 at 12 [emphasis added].

\(^{145}\) Ibid at 45 [emphasis added].

\(^{146}\) In the American context, Daniels and Sabin acknowledge a worry that “the litigious public will accept no limits” on health care plans (“The Ethics”, supra note 3 at 58).
politically salient today.\textsuperscript{147} Constitutional challenges to the administration of health care provide examples of Canadians failing to accept policy-makers’ decisions about health care rationing.\textsuperscript{148} Unhappiness with coverage decisions also suggests an implicit issue with the reasons for those decisions (though one may also critique a decision on procedural grounds). Yet Canadian calls for greater coverage are rarely paired with calls to overhaul the Medicare decision-making procedures and there are few constitutional challenges raised relative to the number of insured Canadians. Both signs of a lack of acceptance of reasons may demonstrate pockets of discontent, rather than wholesale disagreement with the decision-making process or the reasons for decisions made within that process. The Canadian public’s limited disagreements with the current system may simply exemplify the claim that no one will accept all rationing decisions, putting Canada on par with other countries. Yet it is also difficult to take the lack of widespread protest and/or challenges to the reasons for health care rationing decisions as being dispositive of whether Canadians accept those reasons. A lack of public anger could be emblematic of a lack of public awareness of the reasons for decisions, rather than public acceptance of those reasons. Relative silence should not be read as acceptance when one is gauging the acceptance of governmental decisions on a wide scale. Given the opacity of reasons provided for decisions made under the three programs listed above, lack of awareness is a likely explanation for the lack of public response to these decisions. We need better access to reasons to assess whether the public accepts them. Even a good survey on whether people accept reasons for decisions will require the provision of those reasons. The evidence for whether Canadians accept reasons for decisions is thus mixed, but the lack of response to some reasons may be better explained by a lack of awareness than acceptance.

\textsuperscript{147} Newspaper articles on calls for increased coverage appear periodically. See e.g. Andre Picard, “Doctors’ Orders: Expand Medical Coverage to Long-Term Care”, \textit{The Globe and Mail} (21 August 2007), online: <www.theglobeandmail.com/news/national/doctors-orders-expand-medical-coverage-to-long-term-care/article692138>.

The hypothetical “acceptability” of reasons used to make decisions about Canadian health care distribution is similarly difficult to parse. Daniels and Sabin structure their analysis in terms of the views of “fair-minded people.” Some further detail on their characteristics is necessary to perform the hypothetical agreement thought experiment. Daniels and Sabin’s fair-minded people are “people who in principle seek to cooperate with others on terms they can justify to one another. … [They] seek reasons … they can accept as relevant to meeting consumers’ or citizens’ needs fairly under resource constraints.”\(^{149}\) This explanation is unhelpful if we do not know what reasons these fair-minded people are being asked to hypothetically accept. That information is lacking in Canada. In the abstract, it seems reasonable to assume that fair-minded persons could accept decisions made on the basis of what is “medically necessary” and “medically required.” The aforementioned lack of protest against use of these terms in current reasoning provides (weak) evidence that Canadians not only could, but do accept those reasons in at least some cases (though, again, silence should not be read as acquiescence in this case). Yet the undefined status of those two terms means that they are, in practice, open to wide interpretation. On a wide enough interpretation, the phrases lack substantive content. Even the guiding principles on how to interpret these terms are generally undefined.\(^{150}\) The threat of arbitrary decision making looms. In their original work on Canadian AFR, Flood and Zimmerman state that resource allocation “decision-making [in Canadian medicare] is generally opaque.” Lack of transparency allows decision making on an \textit{ad hoc}, politicized basis.\(^{151}\) They suggest that the lack of transparency “allows for the possibility of self-interest or irrelevant considerations to guide these fundamental decisions.”\(^{152}\) In the absence of public reasons for decisions, it is unclear to what extent arbitrary decision making is made possible or actually allowed. Yet fair-minded individuals clearly would not accept arbitrary decision making. Such individuals are defined by their commitment to relevant reasons and arbitrary decisions are by definition not based on relevant reasons. If medical necessity is a proxy for political expediency, as Flood and Zimmerman worry, hypothetical agreement is unlikely.

\(^{149}\) Daniels & Sabin, \textit{Setting Limits}, supra note 1 at 44. Elsewhere, Daniels and Sabin suggest that fair-minded people seek cooperation on “mutually justifiable” terms (“The Ethics”, supra note 3 at 51).

\(^{150}\) Flood & Zimmerman, supra note 4 at 30.

\(^{151}\) \textit{Ibid} at 27.

\(^{152}\) \textit{Ibid} at 30.
Even if decisions are in fact non-arbitrary, focus on the criteria of “medically necessary” and “medically required” alone do not get us far in the absence of substantive definitions for those terms. Decisions based on empty concepts may seem less problematic, but fair-minded individuals are still unlikely to accept that such decisions were fairly made. If evidence suggests that Canadians accept the reasons for health care rationing decisions, this could be evidence that current Canadians are insufficiently fair-minded. It is certainly the case that the reasons for decisions acquire some legitimacy from the fact of their being a product of fair legislative processes. The medical necessity and requirement criteria, for instance, are explicitly contained in the CHA and provincial Medicare implementation statutes. Yet fairly elected legislators can make decisions on the basis of inadequate reasons. Accepting that a government is a legitimate decision maker is not tantamount to accepting that all of its decisions are fair. Failing to object to long-standing practices of government, such as the use of the medical necessity and requirement criteria for Medicare decisions, does not necessarily constitute acceptance of such practices, particularly where details on how those criteria are understood in those practices are difficult to parse. Even when those decisions are sufficiently transparent as to make the decision-making process procedurally fair on one axis, transparent but unacceptable reasons are unreasonable and thus suggest that full procedural fairness is lacking. Moreover, even if citizens accept these poor reasons, this acceptance may be mistaken and fail to contribute to one of the interpretations of the acceptability criterion for accountability for reasonableness outlined above.

Ultimately, then, there is insufficient evidence to suggest that Canadians accept the reasons for decisions in the Canadian health care context and ample evidence that they lack access to sufficiently fine-grained parsing of those reasons to either actually or hypothetically accept them. Focusing on the IFHP does not improve Canada’s score on this metric. Given the lack of transparency in the IFHP, it is difficult to even apply the accepted or acceptable reasons metrics to the program. While most would agree that the need for “short term, interim medical care” is an acceptable reason for government action, it is likely too vague a description to guide specific decisions on what to cover. It also does not explain what is covered at present. Given that the reasons for the proposed cuts to the program were both widely criticized by the public (who protested the cuts) and found to be inadequate to justify rights violations in a free and democratic society by the FC in the aforementioned Refugee Care case, it is clear that the reasons for those changes were not widely
accepted.\textsuperscript{153} The reasons given by the federal government for the cuts could be \textit{acceptable} reasons for government action in the abstract, but still likely did not justify the tiered system of coverage. For instance, positing cost-cutting as a justification for the cuts did not withstand critical scrutiny. Provincial governments and scholars both worried that any savings from the 2012 cuts to the program would result in downloading of costs to the provinces.\textsuperscript{154} While the FC did not rule on whether the cuts would actually reduce costs – though they did hold that the cuts may “result in a reduction of costs to the program”\textsuperscript{155} – there is evidence that when the cuts were in place, costs were downloaded to, for example, hospitals that continued to admit anyone who presented with an emergency.\textsuperscript{156} This downloading raised serious questions about whether the proposed regime would be more cost-effective than the 2012 regime. There is, moreover, still no evidence that the 2012 program was unfair to Canadians or that the current program will lead to abuse of the system. It is unclear why some groups received basic and prescription coverage, some groups received basic coverage and PHPS prescription coverage, and some groups only received categories of PHPS coverage. Some categories tracked either vulnerability or some sense of desert. For instance, a less cynical view is that the IFHP prioritized pregnant women, children, and victims of human trafficking because they are the most vulnerable of the (already vulnerable) categories of refugees. Yet it may be that these categories were just a proxy for concerns related to desert. Perhaps there was an (unfounded) sense that these refugees were somehow less apt to abuse the system. The previous federal government’s references to “bogus” refugee claimants in their justification of the cuts appeared to presume that claimants from DCOs were bogus in the absence of evidence to the contrary.\textsuperscript{157}

\begin{footnotesize}
\begin{itemize}

\item Barnes, \textit{supra} note 91 at 8.

\item \textit{Refugee Care}, \textit{supra} note 64 at para 945.


\item For use of the term “bogus” to justify the cuts, see \textit{Refugee Care}, \textit{supra} note 64 at para 56, citing the Minister of Citizenship and Immigration’s spokesperson in 2012, soon after the changes came into force.
\end{itemize}
\end{footnotesize}
Even if one takes the less cynical view of these categories, the concerns regarding fairness and abuse did not explain all the different categories. For instance, if there was a concern that too many benefits would cause "bogus" claimants to come forward, why provide them with basic coverage while they awaited decisions on their claims? Public health and safety concerns likely explained why all claimants received PHPS coverage. Yet those concerns did not explain why some groups received only PHPS coverage between 2012 and 2016, particularly when preventative medicine, which falls under “basic” coverage, is often an effective means of preventing public health and safety emergencies. While the reasons for the 2012 cuts to the IFHP could theoretically have been acceptable reasons for government action, they could not have justified the tiered coverage that the previous federal government attempted to put in place.

The NIHBP again provides a minor exception to the story of Canadian failure under this aspect of AFR, but the program’s small successes likely do not suggest best practices for producing acceptable or accepted reasons for decisions that can then be applied in other areas of the Canadian health care system. If one accepts that the aforementioned principles are acceptable reasons for the NIHBP’s decisions, then the program also fares reasonably well on the acceptability-based public reason standard. Costs, the needs of relevant stakeholders, the use of scientific research, and attentiveness to relevant alternatives seem like acceptable reasons in the abstract. Yet the acceptability of these reasons for particular decisions will depend on context. As noted in my discussion of the IFHP, cost containment can be an unacceptable reason for failing to insure a good where there is insufficient evidence that, in so doing, program costs will in fact be reduced. It would thus also be helpful to know more about the particular scientific research on which the government bases its decisions in order to undertake a more fine-grained analysis of the acceptability of its reasons for decisions; bad science produces bad reasons for action. Despite these caveats, the broadly defined reasons for decision making in the NIHBP are ostensibly acceptable reasons in the abstract for health care allocation, so a more coarse-grained acceptability analysis counts in the program’s favour. While the acceptability of reasons can be hard to define, the abstract acceptability of the NIHBP’s reasons for drug coverage helps explain what is covered (providing a fit between reasons and actions that will support acceptance of both) and why the reasons are rarely challenged in courts or targeted by large protests. These facts suggest that the guiding reasons in the NIHBP are generally accepted. Greater Aboriginal input in deciding what will be covered would improve actual acceptance. Yet the NIHBP fares reasonably well on acceptability and acceptance-based public reason analyses at present. Given the high level of
generality of the principles and the contextual factors that determine whether the principles are actually accepted, it is unlikely that these reasons can easily be imported as reasons for decisions in other aspects of the Canadian health care system without further elaboration.

VI. THE REVIEWABILITY REQUIREMENT: THE PRESENCE OF CHALLENGE/APPEAL PROCEDURES IN THE CANADIAN HEALTH CARE SYSTEM

There are several challenge and appeal procedures related to the Canadian legal regulation of health care. One can challenge decisions on health care coverage and provision using constitutional law, human rights law, or general administrative law. The first two procedures can be summarized briefly. Sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* protect rights to “life, liberty and security of the person” and “equality” respectively and allow for the challenge of any Canadian law.¹⁵⁸ Both sections have been used to challenge aspects of Canada’s regulation of health care and even to demand provision of certain goods.¹⁵⁹ Section 12 of the Charter was also successfully invoked in the aforementioned challenge to the proposed cuts to the IFHP.¹⁶⁰ Every province also has a human rights tribunal.¹⁶¹ If one feels that one has been discriminated against in the coverage or provision of health care, one can challenge the decision before the tribunal.¹⁶²

---

¹⁵⁸ *Supra* note 35.

¹⁵⁹ See e.g. *Eldridge*, *supra* note 148; *Auton*, *supra* note 148.

¹⁶⁰ *Refugee Care*, *supra* note 64.

¹⁶¹ These are created by provincial human rights acts and their associated regulations. See e.g. Ontario’s *Human Rights Code*, RSO 1990, c H.19, ss 35ff.

¹⁶² *Chaoulli*, *supra* note 148, is actually best understood as a provincial human rights case, though subsequent challenges highlight the quasi-constitutional status of Québec’s human rights legislation to suggest that the case also has constitutional implications. See also *Waters v British Columbia (Ministry of Health Services)*, 2003 BCHRT 13, 46 CHRR D/139 [*Waters*]; *Newfoundland and Labrador v Sparkes*, 2004 NLSCTD 16, 131 ACWS (3d) 488 [*Sparkes*]; *Hogan v Ontario (Minister of Health and Long-Term Care)*, 2006 HRTO 32, 58 CHRR D/317; *Finan v Cosmetic Surgicentre (Toronto) Inc*, 2008 HRTO 47, 64 CHRR D/106; *Turnbull v British Columbia (Ministry of Health Services)*, 2011 BCHRT 324, [2011] BCHRTD No. 324 [*Turnbull*]; *XY v Ontario (Minister of Government and Consumer Services)*, 2012 HRTO 726, 74 CHRR D/331; *Refugee Care*, *supra* note 64.
Successful challenges require that one establish that one has been denied health care that is generally provided to others, that the denial is related to an enumerated ground, which human rights law is designed to protect (or an analogous ground), and that the government lacks a defence for the prima facie discriminatory denial of treatment. These tribunal decisions are then themselves reviewable by courts.

General (non-human rights) administrative law avenues require a more lengthy discussion. Flood and Zimmerman only list Ontario, Alberta, and British Columbia (BC) as provinces with “administrative tribunals to which the citizens thereof can bring … an application to review a decision not to publicly fund a service or a treatment” and briefly mention that Québec’s “Tribunal administratif du Québec hears appeals concerning health treatment or service coverage.” This list is arguably under-inclusive. Ontario, Québec, and Alberta maintain appeal mechanisms for (at least some) health insurance decisions. In Ontario, “[a]n insured person who has made a claim for payment for insured services may appeal a decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less than the amount payable by the Plan.” In Québec, “[a]n insured person or person eligible for a plan or program … who believes he has been wronged by a decision of the [Régie de l’assurance maladie du Québec] may apply for a review of the decision” at the Tribunal administratif du Québec. Under Alberta regulations, there is a limited right of review of one’s request for out-of-country provision of services not available in Canada. Yet other provinces also allow for limited administrative appeals. The Manitoba Health Appeal Board has the power to hear appeals on several

---

163 These criteria can be established by reading the requirements for prima facie discrimination in Moore v British Columbia (Education), 2012 SCC 61 at para 33, [2012] 3 SCR 360 [Moore] together with the defence requirement in Ontario (Human Rights Commission) v Simpsons-Sears Ltd, [1985] 2 SCR 536 at 558–59, 23 DLR (4th) 321 and transposing them into the health care context. While Moore only interprets a single provincial human rights act, the structural similarities between all Canadian human rights acts suggests that this test applies in all provinces.

164 Flood & Zimmerman, supra note 4 at 34.

165 HIA, ON, supra note 53, s 20(1)(b).

166 Health Insurance Act, CQLR c A-29, s 18.1 [HIA, QC].

grounds, including appeals by those who have been “denied entitlement to a
benefit under [The Health Services Insurance Act] or the regulations,”168 and
New Brunswick regulations charge the Insured Services Appeal Committee
with “advis[ing] the Minister on appeals by persons on matters in dispute or
disagreement with respect to … refusal of a claim for payment for entitled
services or reduction of the amount so claimed.”169 These provinces suggest
that Canada fares better on AFR’s challenge/appeal component than previ-
ously thought.170

In nearly every case, administrative decisions can then be reviewed by
courts. For instance, Ontario explicitly states that people making challenges
under their system have a right of appeal to the Divisional Court after an
HSARB decision.171 In Manitoba, the statute outlining the powers of its
equivalent review board does not explicitly refer to a right of review at
court, but it is also not barred.172 Albertan laws are generally silent on how
Albertan appeal mechanisms work.173 There is, then, an extra level of pos-
sible challenge before the judicial level in several Canadian provinces and
none of these challenges preclude further review at court.174 This also counts

168 Health Services Insurance Act, RSM 1987, c H35, CCSM c H35, s 10(1)(b)
[HSIA].

169 NB Reg 84-20, s 33.01(2)(b).

170 Nova Scotia took steps to recognize an appeal board, but has not yet estab-
lished one. The Insured Health Services Act, SNS 2012, c 44 (4th Sess), ss
39–51, would establish the Insured Health Services Appeal Board and outline
its powers relative to other judicial appeal bodies, but since it has only been
enacted and not proclaimed, the statute has not come into force.

171 HIA, ON, supra note 53, s 24(1).

172 HSIA, supra note 168.

173 See e.g. Alberta Health Care Insurance Act, RSA 2000, c A-20; Out-of-Coun-
try, supra note 167.

174 There are no references to review or appeal mechanisms for would-be patients
in the health insurance acts of Newfoundland and Labrador (Medical Care In-
surance Act, 1999, SNL 1999, c M-5.1), Nova Scotia (Health Services and
Insurance Act, RSNS 1989, c 197), Prince Edward Island (Health Services
Act, RSPEI 1988, c H-1.6), Saskatchewan (The Saskatchewan Medical Care
Insurance Act, RSS 1978, c S-29) or the territories (Health Care Insurance
Plan Act, RSY 2002, c 107; Hospital Insurance and Health and Social Services
Administration Act, RSNWT 1988, c T-3). In Québec, arbitration is required
for disputes arising from “an agreement” (i.e., “an agreement with the repre-
in favour of Canada’s challenge/appeal score. No legislation bars judicial review of IFHP decisions. Judicial review of NIHBP decisions is theoretically possible if internal review procedures are exhausted.

Ombudspersons provide another example of an administrative entity to whom one can formally challenge health care allocation decisions.\(^{175}\) The existence of this avenue for challenging and reviewing government decisions contributes to the Canadian health care system’s reviewability. Ombudspersons come in two relevant forms: general ombudspersons and health care-specific ombudspersons. First, every province except Prince Edward Island has legislation enabling ombudspersons to hear complaints concerning government action and work to resolve outstanding issues.\(^{176}\) These general ombudspersons can then make recommendations to different entities about how to resolve the issue. They possess different levels of jurisdiction over health care,\(^{177}\) but ombudspersons with adequate jurisdiction may provide a limited tool for securing or expanding entitlements. While ombudspersons lack authority to enforce their recommendations, some have high compliance rates with their decisions; the Québec Ombudsman claims 97% of its recommendations are approved.\(^{178}\) Second, Québec and

---

\(^{175}\) See e.g. Public Protector, supra note 176, s 13; OA, SK, supra note 176, s 14; OA, AB, supra note 176, ss 12, 12.1, 28(3); OA, BC, supra note 176, Schedule; OA, NB, supra note 176, Schedule A; OA, YT, supra note 176, ss 18, 20; CRA, supra note 176, Schedule; OA, NS, supra note 176, s 1; OA, ON, supra note 176, s 14; OA, MB, supra note 176, ss 15, 22.

\(^{176}\) For an example focused primarily on Québec, see Catherine Régis, “The Accountability Challenge in Health Care: The Contribution of a Health Ombudsman” (2014) 4:1 J of Arbitration & Mediation 87.

\(^{177}\) See e.g. Public Protector, supra note 176, s 13; OA, SK, supra note 176, s 14; OA, AB, supra note 176, ss 12, 12.1, 28(3); OA, BC, supra note 176, Schedule; OA, NB, supra note 176, Schedule A; OA, YT, supra note 176, ss 18, 20; CRA, supra note 176, Schedule; OA, NS, supra note 176, s 1; OA, ON, supra note 176, s 14; OA, MB, supra note 176, ss 15, 22.

Alberta recognize health care-specific ombudspersons who are granted the authority to discharge legislative “patients’ bills of rights” (that also exist in jurisdictions without ombudspersons). These bills consolidate existing rights and sometimes grant additional rights. In Québec and Alberta, they can ground complaints about the public health care systems. In Québec, at least, the ombudsperson is then duty-bound to make recommendations to specific governmental entities (e.g., ministries, bureaucratic administrators, and governments themselves) as to how to protect the bill’s enumerated rights, though the ombudsperson lacks the authority to provide this protection on his or her own. Some scholars suggest that the presence of “an economical, easily accessible and independent complaints process,” which can amount to an ombudsperson, is necessary for the patients’ bill of rights

---

179 See Act Respecting Health Services and Social Services, CQLR c S-4.2; Act Respecting the Health and Social Services Ombudsman, CQLR c P-31.1, s 7 [Health Ombudsman Act]; Alberta Health Act, SA 2010, c A-19.5, s 2 [AHA]; Health Advocate Regulation, Alta Reg 49/2014, ss 1, 2, 4 [HAR]. The “patients’ bill of rights” language is not uniform across jurisdictions. It is nonetheless a useful catch-all for related terms such as “patients’ charter,” and is accordingly viewed as equivalent in, e.g., Mark Ammann & Tracey Bailey, “Alberta’s Patient Charter: Is It a Course Worth Charting?” (2011) 19:2 Health L Rev 17; Colleen M Flood & Kathryn May, “A Patient Charter of Rights: How to Avoid a Toothless Tiger and Achieve System Improvement” (2012) 184:14 CMAJ 1583. For an earlier article addressing these bodies, which uses the “bill of rights” language, see Colleen M Flood & Tracey Epps, “Waiting for Health Care: What Role for a Patients’ Bill of Rights?” (2004) 49:3 McGill LJ 515.

180 AHA, supra note 179; Health Ombudsman Act, supra note 179, s 7; HAR, supra note 179, s 4.

181 Health Ombudsman Act, supra note 179, ss 7, 20, 24; Flood & May write that patients’ bill of rights, which are also recognized in non-Canadian jurisdictions, “do not generally grant formal legal rights…. [T]hey can act as a catalyst through which to resolve individual patient concerns quickly and economically” (supra note 179 at 1583). On this reading, new rights established in a patients’ bill of rights are mere aspirations. One could alternatively understand them as moral rights that are legally recognized, but are not legally enforceable. This would explain why Nova Scotia passed legislation recognizing aspirational ideals rather than a patients’ bill of rights: Ammann & Bailey, supra note 179 at 20. Governments may alternatively see patients’ bills of rights as legally enforceable even if they do not create entities to enforce them, which would create incoherence between rights recognized in, and duties imposed by, the bills. There would be formal legal recognition of the rights, without the corresponding duties.
to have teeth, but health care-specific ombudspersons and patients’ bills of rights could exist without one another. Other provinces could soon follow Québec and Alberta by creating new fora for lodging complaints. For instance, while Ontario’s past attempts to establish a patients’ bill of rights and to create an entity to protect those rights failed, past failure is not necessarily an indicator of future failure. There are signs that similar legislation could be enacted in Ontario in the near future. Long-term care residents in Ontario already possess a codified set of rights established by the provincial Long-Term Care Homes Act, 2007. In late 2015, Ontario appointed its first patients’ ombudsperson under 2014 amendments to the Excellent Care for All Act, 2010. This development potentially presages legislative recognition of patients’ rights outside the long-term care setting. The addition of new health care ombudspersons will further increase Canada’s health care reviewability, even if their limited powers mean that they cannot ensure actual revisions of government decisions on their own and thus do not perfectly fulfill the reviewability criterion envisioned by Daniels and Sabin.

Constitutional law, human rights law, and the general (non-human rights) administrative law of several provinces, then, allow for challenges

---

182 Flood & May, supra note 179 at 1583.

183 Indeed, Québec’s patients’ bill of rights existed before the Health and Social Services Ombudsperson was established, and the bill was originally enforced by another entity: Ammann & Bailey, supra note 179 at 19. See also ibid at 21–23, which accordingly distinguishes questions concerning whether a patients’ bill of rights should exist from questions concerning whether an entity should be created to enforce it.

184 Ibid at 20 (stating that there have been three attempts by government to create an Ontario patients’ bill of rights).


186 SO 2007, c 8, s 3.


188 As discussed in notes 181 and 183, recognition of an ombudsperson does not necessarily lead to recognition of a bill; these legal tools can be separated. For instance, BC invokes the language of the “patients’ bill of rights” in a regulation, but the text does not grant specific rights or create an entity to protect them: Patients’ Bill of Rights Regulation, BC Reg 37/2010.
or appeals, or both, of health care allocation decisions. To fulfill the AFR conditions, these mechanisms must allow for the revision of challenged decisions. This is formally available under all of the challenge and review mechanisms listed here. Whether these mechanisms are an effective means of challenging decisions that actually lead to the revision of decisions is a further concern. Daniels and Sabin do not explicitly require substantive revision at any level, but their framework seems to imply that revisions ought to take place. A reviewability criterion without any prospect of effecting change is of little value; without such a criterion, it is difficult to see how AFR can fulfill its promise of ensuring the type of representativeness health care justice demands as captured, for example, by Premise 4 above. There is reason to question the extent to which Canadian mechanisms result in real change. Successful constitutional claims in the health care domain are rare at best. 189 The mechanisms available under general administrative law faces similar concerns. Flood and Zimmerman only identified one “successful substantive administrative law challenge in health rationing” and that case merely secured reimbursement for the provision of a specific health care good. 190 Ombudspersons rely on governments’ political will to enforce their

189 A right to sign language interpretation in a hospital setting was recognized in Eldridge, supra note 148. Yet there is some debate about whether this constitutes a health care service. As Colleen M Flood notes, access to the service is minimal throughout much of Canada even after Eldridge: “Litigating Health Rights in Canada: A White Knight for Equity?” in Flood & Gross, The Right to Health, supra note 26, 79 at 89–90. Challenges to criminal prohibitions on health care goods or services did meet with some success in Morgentaler, supra note 148; Insite, supra note 148; and Carter, supra note 43. Refraining from criminalizing access to health care services is not the same as guaranteeing the right to have a health care good covered by public health insurance, but most other health rights-based litigation brought before the Supreme Court of Canada has not resulted in a court-mandated entitlement. Lower court decisions have not been any more promising. The Federal Court of Appeal (Toussaint v Canada (AG), 2011 FCA 213 at paras 77–80, [2013] 1 FCR 374, leave to appeal to SCC refused, 34446 (5 April 2012) [Toussaint]; Covarrubias v Canada (Minister of Citizenship and Immigration), 2006 FCA 365 at paras 33–37, [2007] 3 FCR 169), the Federal Court (Refugee Care, supra note 64 at para 571), and the Ontario Court of Appeal (Flora v Ontario (Health Insurance Plan, General Manager), 2008 ONCA 538 at paras 105–08, 295 DLR (4th) 309) have all stated that there is no positive right to have a particular medical service covered under a health insurance regime or to otherwise have the government provide a particular health care service.

190 Supra note 4 at 52–53, citing Stein v Québec (Régie de l’assurance-maladie), [1999] RJQ 2416, AZ-99021819 (Azimut) (Sup Ct).
recommendations; they cannot ensure substantive changes on their own. Finally, human rights law presents a mixed bag. As Nola M Ries makes clear, it has successfully been used as a channel to obtain reimbursement for otherwise uninsured goods, to ensure that professionals provide goods on a non-discriminatory basis, and to reduce wait times. However, it is not always a successful avenue. Fully evaluating the potential efficacy of these three legal review mechanisms is beyond the scope of this article. Nevertheless, their existence counts in favour of Canada’s legal regulation of health care on the original formulation of the AFR framework.

The IFHP does not appear to have a specific appeal process but, as noted above, it does not attempt to preclude judicial review. One can, for instance, go directly to the FC for judicial review of a denial of coverage and can invoke administrative and constitutional law arguments in one’s challenge. All of the aforementioned legal tools should be available to IFHP claimants and most of the same caveats about the effectiveness of these tools apply. IFHP decisions rarely lead to judicial cases. The aforementioned challenge to the proposed 2012 changes, however, suggests that constitutional law can be used to make substantive changes to the IFHP. While the IFHP lacks specific review procedures and general coverage decisions rarely receive judicial review, then, the major instance of judicial review of IFHP policies, Refugee Care, suggests that there are other powerful legal tools for challenging decisions made about the program.

---

191 “Charter Challenges” in Downie, Caulfield & Flood, supra note 5 at 634–35.
192 Waters, supra note 162.
194 Sparkes, supra note 162.
195 See e.g. Turnbull, supra note 162 (just one of many examples of failed claims for health care coverage under human rights law).
196 This process was famously followed by Nell Toussaint, though she ultimately lost her challenge before the Federal Court and the Federal Court of Appeal: Toussaint, supra note 189.
197 E.g., a 28 January 2016 Westlaw search for “Interim Federal Health” only unearthed 22 judicial, board, or tribunal decisions, several of which were different level decisions in the same cases.
198 Supra note 64.
The NIHBP also does not bar judicial review of its decisions, but the requirement that individual claimants exhaust inter-departmental administrative appeal channels before requesting judicial review may delay access to judicial proceedings. This would be acceptable if the issues raised were resolved without requiring judicial review and thus without the use of limited judicial resources. Yet this internal appeals process may also delay resolution of an issue that does warrant judicial review. As with the IFHP, very few cases make it to judicial review and only a small number of those cases concern individual claimants challenging coverage. This suggests that the substantive reviewability of the NIHBP, namely the ability of appeals and challenges brought by individuals to effect substantive changes in the program, may be limited. Challenges to the implementation of the program, on the other hand, may not require initial inter-departmental appeals. Service providers could, in theory, challenge the implementation of the program before human rights tribunals and requested judicial review of those decisions. Yet a successful challenge, such as the aforementioned challenge to the government’s proposed changes to the IFHP in Refugee Care, is absent in the NIHBP context. The bar on appeals of decisions about excluded goods also undermines the reviewability of the NIHBP by precluding review of the absence of coverage of essential vaccines and other goods.

Ultimately, then, there are review or challenge procedures throughout the Canadian health care system. The value of these procedures for securing actual substantive changes to initial decisions is, however, limited. I examine the relative merits of review versus challenge procedures as mechanisms for expanding health care entitlements in greater detail elsewhere. For now, it suffices to note that constitutional law has been (admittedly rarely) successfully used to make changes in the Medicare and IFHP contexts, human rights law has a mixed history in the Medicare and NIHBP contexts, and general administrative law has a limited history of success. Challenge

---

199 A Westlaw search for cases mentioning the “Non-Insured Health Benefits Program” on 28 January 2016 only identified 25. Even a search that did not require exact phrasing (omitted quotation marks) only returned 72 judicial cases and 41 board or tribunal decisions, many of which involved insurance agencies rather than individual claimants. A search for “NIHB” only unearthed seven board or tribunal decisions, and 11 judicial decisions.

200 DBL 2016, supra note 104 at viii.

201 See the chapter of my forthcoming doctoral dissertation devoted to administrative law: Michael Da Silva, Realizing the ‘Right’ to Health Care in Canada (SJD Thesis, University of Toronto, 2017) ch 7 [unpublished].
and review mechanisms are nominally available, but they may not result in substantive changes.

VII. The Right to Health Care and Progressive Realization: A Further Concern

If one believes that the AFR framework can be a useful mechanism for analyzing the international right to health care, then the AFR conditions can also serve as metrics for determining the extent to which states are meeting the procedural goals of the right to health care. International human rights law does not oblige states to comply with AFR as developed by Daniels and Sabin, but AFR may provide insight as to how to track what those international obligations ought to achieve. I conclude this piece by examining how this could be the case for the “progressive realization” component of the international right to health care.

The international right to health care requires that states progressively realize components of the right to health care. The Universal Declaration of Human Rights calls on “every individual and every organ of society” to take “progressive measures, national and international, to secure … universal and effective recognition” of human rights and freedoms. The International Covenant on Economic, Social and Cultural Rights, in turn, requires that parties “take steps” towards fulfilling social rights recognized in the Covenant “with a view to achieving progressively [their] full realization.” This means that states that cannot fulfill all their duties immediately (due, for example, to resource constraints) must fulfill more of their duties over time. Once they take these steps and fulfill these demands, moreover, they cannot cease fulfilling their obligations. International human rights law explicitly states that one cannot be “deliberately retrogressive”

---

202 As noted at 113–14, above, international human rights law recognizes a broader right to health. An international right to health care can be carved out of that broader right by focusing on provisions related to health care goods and services, rather than the social determinants of health. As a component of the broader right to health, the international right to health care shares many features of the broader right. The “progressive realization” component is just one example.


204 ICESCR, supra note 23, art 2.
in one’s realization of the right to health care.\textsuperscript{205} When combined with the AFR framework, this progressive realization framework allows for a useful way of analyzing the extent to which states are meeting the procedural components of the right to health care. If one takes the procedural justice and progressive realization components of the international law right to health care seriously, the addition of a procedural safeguard or review/appeal mechanism demanded by the AFR framework contributes to nations’ right to health care achievements. The elimination of a safeguard or review/appeal mechanism ought to count against it. This understanding allows for further analysis of the Canadian health care system and the legal regulation thereof.

Procedurally progressive measures in the legal regulation of Canada’s health care system can be identified. Alberta’s creation of a health care ombudsperson and patients’ bill of rights increases reviewability. Ontario’s recognition of a health ombudsperson does the same, even in the absence of a patients’ bill of rights. The additional online fora for reading Ontario and Québec’s health care appeal decisions mentioned above are progressive steps towards transparency that have been taken since Flood and Zimmerman conducted their earlier work on the Canadian health care system’s procedural fairness. Still, as the foregoing made clear, the provision of public reasons for original decisions about which health care goods are covered needs to be made mandatory before the progressive realization of accountability for reasonableness measures can be considered to have reached a point where we can properly gauge acceptability. Where the publicity condition is unfulfilled and the acceptability criterion consequently cannot be properly studied, Canada has yet to make sufficient progress in its fulfillment of the AFR conditions to even complete the AFR analysis. Canada is doing better, but further work needs to be done.

The history of deliberate retrogression in the Canadian context also concerns procedural aspects of Medicare. The recent history of Medicare does not offer many instances of substantive deliberate retrogression. Groups of people are not frequently removed from coverage without warrant. Large-scale cutbacks in the list of insured goods are rare. Deliberate retrogression in the provision of procedural protections is more common. For instance,

the HSARB’s jurisdiction was limited in recent years.\textsuperscript{206} This minimized its ability to secure procedural justice in health care, and has made it more difficult for people to use the board to secure or expand their health care entitlements. This deliberate retrogression in procedural fairness thus serves as a bar to increased access to goods. The most striking violation of the progressive realization of the procedural aspect of the right to health care, however, is the seeming disappearance of BC’s administrative appeal body for health insurance coverage and provision. In their original work on the Canadian health care system’s accountability for reasonableness, Flood and Zimmerman identified BC as one of the few provinces that allowed for an appeal of health care insurance decisions.\textsuperscript{207} Yet BC’s relevant legislation no longer outlines the powers of any appeal body, including the Medical and Health Care Services Appeal Board (MCSAB) highlighted by Flood and Zimmerman.\textsuperscript{208} The BC Ministry of Health’s online list of “Colleges, Boards and Commissions” highlights the Medical Services Commission, the first instance decision maker, and 11 related boards, but does not list the MCSAB or any other board that fulfills all of its previous functions.\textsuperscript{209} The

\textsuperscript{206} Ministry of Health and Long-Term Care Appeal and Review Boards Act, 1998, SO 1998, c 18, Schedule H, s 6(1), 6(3). HSARB now accepts a bar on its ability to consider constitutional issues: \textit{EH v Ontario (Health Insurance Plan)}, 2011 CanLII 67509 at paras 10–12 (Ont HSARB).

\textsuperscript{207} Flood & Zimmerman, \textit{supra} note 4 at 34.

\textsuperscript{208} \textit{Ibid}; \textit{Medicare Protection Act}, RSBC 1996, c 286, ss 41–44, 45.1 [MPA]. See also \textit{Hospital Insurance Act}, RSBC 1996, c 204. There is a reference to “each former member of” that board in a list of persons “engaged in the administration” of the \textit{MPA}, but this is one of the only legal recognitions of the board and reference to it is made in the past tense (\textit{ibid}, s 49). Appeals to the province’s Supreme Court remain possible.

\textsuperscript{209} British Columbia has several appeal bodies related to professional regulation and certification for eligibility under particular allocation regimes, but the only body listed by the province that specifically addresses insured benefits is the Medical Services Commission, a first instance decision maker. Per the province:

\begin{quote}
The Medical Services Commission (MSC) manages the Medical Services Plan … in accordance with the Medicare Protection Act and Regulations. … The responsibilities of the MSC are two-fold: to ensure that all B.C. residents have reasonable access to medical care and to manage the provision and payment of medical services in an effective and cost-efficient manner (“Medical Services Commission” (2016), online: <www2.
MCSAB no longer maintains a website and it appears to no longer exist. At best, it is no longer publicly promoted. This suggests deliberate retrogression in procedural fairness in a Canadian province. There may be good reasons to disband the Board (or to remove its presence online), but these reasons are at least partially offset by the resulting reduction of accountability for reasonableness. Luckily, the addition of new ombudspersons in Canada should serve as progress in this arena and at least partially offset this diminished reviewability.

IFHP and NIHBP processes, by contrast, are largely stable. There are some signs of minor procedural progress in the NIHBP’s transparency. Since 2012, it has published an online newsletter for clients that is “intended to inform them about their coverage … as well as updates and changes to NIHB[P] policy and benefit information.” A new price file, which explains how the program applies to incontinence-related goods, also tries

---

The listed boards are the Hospital Appeal Board, the Community Care and Assisted Living Appeal Board, the Patient Care Quality Review Boards, and the Health Professions Review Board. The website also provides a link to information on the Health Sector Agencies, Boards & Commissions Appointee Remuneration: British Columbia, “Colleges, Boards and Commissions” (2016), online: <www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions>. The Patient Care Quality Review Boards can hear appeals and challenges related to

(i) the delivery of, or the failure to deliver, health care;
(ii) the quality of health care delivered;
(iii) the delivery of, or the failure to deliver, a service relating to health care;
(iv) the quality of any service relating to health care (Patient Care Quality Review Board Act, SBC 2008, c 35, s 1).

However, these challenges concern the decisions and actions of regional health authorities, not the Medical Services Commission: ibid, s 4(1)(a)(i). The Patient Care Quality Review Board should improve BC’s challenge score, but it does not replace the Medical and Health Care Services Review Board function as an appeal mechanism.

---

to make the NIHBP more transparent to health care providers.\textsuperscript{211} The procedural components of the NIHBP and the IFHP otherwise remain stable (despite the recent largescale substantive changes to the latter).

\section*{Conclusion}

The AFR framework provides useful tools for analyzing the extent to which states are ensuring that their health care system and the legal regulation thereof are meeting the procedural requirements of distributive justice. Unfortunately, in three major components of the Canadian health care system, many decisions about which goods individuals are entitled to obtain are made on the basis of reasons that are either shielded from public view or unacceptably vague. Canadian health care thus fails one of the tests for AFR compliance: the public provision of reasons for decisions. This makes it difficult to determine whether Canada meets the second requirement, namely that decisions be made on the basis of publicly accepted or acceptable reasons. Canada’s many appeal mechanisms, including mechanisms not identified in earlier research, provide some insight into the reasons decisions are made by forcing governments to make their reasons public. Those mechanisms thus further count in favour of Canada’s ability to ensure that the nation’s health care system, and the legal regulation thereof, comports with the demands of AFR by increasing its reviewability. The removal of an appeal mechanism from one province suggests a step backwards in meeting the demands of distributive justice in this area, but new ombudspersons help offset this loss in reviewability. These additions, considered along with additional online fora for Medicare appeal mechanisms, raise hope that Canada recognizes a need for greater provision of information in this area and will progressively come to provide the transparency in decision making that AFR demands.

\footnote{\textit{Ibid} at 93.}
The *McGill Journal of Law and Health* wishes to acknowledge the support of the following individuals and organizations:

**Association des étudiant-e-s en droit, Université McGill**

Law Students' Association, McGill University

**Post-Graduate Students' Society, McGill University, Montreal**

Post-Graduate Students’ Society, McGill University

**Work Study Program, McGill University**